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REPORT 95–393
PART 1

MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS

REPORT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

(including cost estimate of the Congressional Budget Office)

ON

H.R. 3

JUNE 7, 1977.—Ordered to be printed

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MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS

JUNE 7, 1977.—Ordered to be printed

Mr. ULLMAN, from the Committee on Ways and Means, submitted the following

REPORT

[Including cost estimate of the Congressional Budget Office]

[To accompany H.R. 3 which on Jan. 4, 1977, was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3) to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the medicare and medicaid programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

1. On page 1, strike out line 5 and all that follows through line 7 on page 27 and insert in lieu thereof the following:

PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

SEC. 2. (a)(1) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such

a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.".

(2) Section 1815 of such Act is amended by adding at the end thereof the following new subsection:

"(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.".

(3) Section 1902(a)(32) of such Act is amended to read as follows:

"(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

"(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a con-

tract arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

"(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;".

(4) The amendments made by this subsection shall apply with respect to care and services furnished on or after the date of the enactment of this Act.

(b) (1) Section 1902(a) of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (35);

(B) by striking out the period at the end of paragraph (36) and inserting in lieu thereof "; and";

(C) by inserting immediately after paragraph (36) the following new paragraph:

"(37) provide for claims payment procedures which (A) ensure that 90 percentum of claims for payment made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 60 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program." ; and

(D) by inserting at the end thereof the following paragraph:

"The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.".

(2) Section 1903 of such Act is amended—

(A) by redesignating paragraph (6) of subsection (a) as paragraph (7);

(B) by inserting after paragraph (5) of subsection (a) the following new paragraph:

"(6) subject to subsection (l), an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the arranging and providing of such programs of educational and technical assistance (provided through such means, including outreach offices, the media, and telephone hotlines, as the Secretary determines to be appropriate) to health care practitioners who furnish, through individual or group practices or through shared health facilities, services covered under the plan, as the Secretary determines are likely to expedite the filing and payment of claims for payment for such services provided by such practitioners; plus" ; and

(C) by inserting after subsection (k) the following new subsection:

"(l)(1) Payment shall not be made under subsection (a)(6) for a quarter ending after September 30, 1980.

"(2) If the aggregate of the amounts of payments to be made in accordance with subsection (a)(6) for any calendar quarter to States exceeds $1,250,000, the amount of the payment to be made under such subsection for the quarter to each such State shall be an amount which bears the same ratio to the amount determined for the quarter under the subsection to the State as $1,250,000 bears to the amount required to make payments for the quarter in accordance with such subsection to all of the States.".

(3)(A) The amendments made by paragraph (1) shall apply to calendar quarters beginning on and after January 1, 1978, with respect to State plans approved under title XIX of the Social Security Act.

(B) The amendments made by paragraph (2) shall apply, with respect to expenditures made, under a State plan approved under title XIX of the Social Security Act, in calendar quarters beginning on and after January 1, 1978.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 3. (a)(1) Part A of title XI of the Social Security Act is amended by inserting immediately after section 1123 the following new section:

"DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

"SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

"(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any

of the programs established by titles V, XVIII, and XIX, or

"(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, and XIX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity.

"(2) As used in this section, the term 'disclosing entity' means an entity which is—

"(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, or a renal disease facility;

"(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX; or

"(C) a carrier or the other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX.

"(3) As used in this section, the term 'person with an ownership or control interest' means, with respect to an entity, a person who—

"(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

"(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or

"(B) is an officer or director of the entity, if the entity is organized as a corporation; or

"(C) is a partner in the entity, if the entity is organized as a partnership.

"(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

"(c) A provider of services (as defined in section 1861(u), other than a fund) shall also include in the information supplied under subsection (a)(1) full and complete information as to the identity of each person with an ownership or control interest in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 per centum or more ownership interest.".

(2) Section 1861(j)(11) of such Act is amended to read as follows:

"(11) complies with the requirements of section 1124;".

(b) Clause (C) of section 1866(b)(2) of such Act is amended by inserting "(i)" after "failed", and by adding after "to verify such information," the following: "or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor,".

(c)(1) Section 1902(a) of such Act (as amended by section 2(b)(1) of this Act) is amended—

(A) by amending paragraph (35) to read as follows:

"(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;";

(B) by striking out "and" at the end of paragraph (36);

(C) by striking out the period at the end of paragraph (37) and inserting in lieu thereof "; and"; and

(D) by inserting after paragraph (37) the following new paragraph:

"(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishings of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), oc-

curring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.".

(2) Section 1903(i)(2) of such Act is amended by inserting before the semicolon at the end thereof the following: ", or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38)".

(d) The amendment made by subsection (a)(1) shall apply with respect to certifications and recertifications made (and participation in the programs established by title V, XVIII, and XIX of the Social Security Act pursuant to certifications and recertifications made), and fiscal intermediary or agent agreements or contracts entered into or renewed, on and after the date of the enactment of this Act. The remaining amendments made by this section shall take effect on the date of the enactment of this Act; except that the amendments made by paragraphs (1) and (2) of subsection (c) shall become effective October 1, 1977.

PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

SEC. 4. (a) Section 1877 of the Social Security Act is amended to read as follows:

"PENALTIES

"SEC. 1877. (a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year or both.

"(b)(1) Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind—

"(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

"(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) Whoever offers or pays any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

"(A) to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

"(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(3) Paragraphs (1) and (2) shall not apply to a discount or other reduction in price obtained by a provider of services or other entity reimbursed under this title on a cost basis, if the reduction in price is properly disclosed and reflected in the costs claimed by the provider or entity as reimbursable under this title.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any

false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.".

(b) Section 1909 of such Act is amended to read as follows:

"PENALTIES

"SEC. 1909. (a) Whoever—

"(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

"(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

"(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

"(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such

plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

"(b) (1) Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in in kind—

"(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

"(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(2) whoever offers or pays any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

"(A) to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

"(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

"(3) Paragraphs (1) and (2) shall not apply to a discount or other reduction in price obtained by an entity reimbursed under this title on a cost basis if the reduction in price is properly disclosed and reflected in the costs claimed by the entity as reimbursable under this title.

"(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as

a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.".

(c) Section 204(a) of Public Law 94–505 (42 U.S.C. 3524) (relating to annual reports of the Inspector General of the Department of Health, Education, and Welfare) is amended by adding at the end thereof the following sentence: "Such report shall also include an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and shall include any recommendations with respect to improving the performance of such activities.".

(d) The amendments made by subsections (a) and (b) shall apply with respect to acts occurring and statements or repsentations made on or after the date of the enactment of this Act.

AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 5. (a) Section 1152(e) of the Social Security Act is amended to read as follows:

"(e) Where the Secretary finds a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required pursuant to provisions of this Act (other than this part) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such Professional Standards Review Organization, except to the extent specified by the Secretary. Nothing in the preceding sentence shall be construed as rendering inapplicable any provision of this Act wherein requirements with respect to conditions for eligibility to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of the kind made pursuant to paragraphs (1) and (2) of section 1155(a)) must be satisfied.".

(b) (1) Section 1154(b) of such Act is amended—

(A) by striking out "(which may not exceed 24 months)" in the first sentence and inserting in lieu thereof "(which may not exceed 48 months except as provided in subsection (c))";

(B) by inserting ", in addition to review of health care services provided by or in institutions," after "perform" in the first sentence; and

(C) by striking out "or ordered by physicians" and all that follows through "and organizations" in the second sentence and inserting in lieu thereof "by or in institutions (including ancillary services) and, in addition,

review of such other health care services as the Secretary may require".

(2) Section 1154 of such Act is further amended by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

"(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.".

(c)(1) Section 1155 of such Act is amended—

(A) by striking out "directly or indirectly involved in" in subsection (a)(6)(A) and inserting in lieu thereof "directly responsible for";

(B) by striking out "any financial" in subsection (a)(6)(B) and inserting in lieu thereof "a significant financial";

(C) by inserting after "to such organization" in subsection (f)(2) the following: ", in a manner similar to that provided for under section 1816(c),"; and

(D) by striking out subsection (g) and inserting in lieu thereof the following new subsection:

"(g)(1) Not later than two years after the date of the enactment of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, the Secretary, through the conduct of demonstration projects or otherwise, shall develop effective ambulatory care review methodologies for use by Professional Standards Review Organizations in performing review responsibility with respect to ambulatory care services.

"(2) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

"(3) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not later than two years after the date the organization has been designated as a Professional Standards Review Organization (other than under section 1154).".

(2) Section 111(a) of such Act is amended by inserting after paragraph (8) the following new paragraph:

"(9) The term 'shared health facility' means any arrangement whereby—

"(A) two or more health care practitioners practice their professions at a common physical location;

"(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

"(C) such practitioners have a person (who may himself be a practitioner)—

"(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

"(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners; and

who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

"(D) at least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding $40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301 of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.".

(d)(1) Section 1158 of such Act is amended by adding at the end thereof the following new subsection:

"(c) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155(a) in connection with such reviews shall constitute the conclusive determination on those issues (subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are

parties to contracts entered into by the Secretary pursuant to section 1842, or single State agencies administering or supervising the administration of State plans approved under title XIX.".

(2)(A) Section 1152(b)(2) of such Act is amended by striking out "submitted to him by the association, agency, or organization" and inserting in lieu thereof "which shall be developed and submitted by the association, agency, or organization in accordance with subsection (h)".

(B) Section 1152 of such Act is further amended by adding at the end thereof the following new subsection:

"(h)(1) During the development and preparation by an organization of its formal plan under subsection (b)(2) or of any modification of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services, the organization shall consult with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located.

"(2) Such plan and any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments.

"(3) The Secretary, before making the findings described in subsection (b)(2) or a finding regarding the organization's capability to perform review of such services (as the case may be), shall consider any such comments submitted to him by such Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification (as the case may be).

"(4) If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, the Secretary shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings become effective.".

(C) Section 1154 of such Act (as amended by subsection (b)(2) of this section) is further amended by adding after subsection (d) the following new subsection:

"(e) In determining whether an organization designated on a conditional basis as the Professional Standards Review Organization for any area is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, the Secretary shall follow the procedures specified in section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).".

(D) Part B of title XI of such Act is amended by adding after section 1170 the following new section:

"MEMORANDUMS OF UNDERSTANDING; FEDERAL-STATE RELATIONS GENERALLY

"SEC. 1171. (a)(1) Except as provided in paragraph (2), no determination made by a Professional Standards Review Organization pursuant to paragraphs (1) and (2) of section 1155(a) in connection with reviews shall constitute conclusive determinations under section 1158(c) for purposes of payment under title XIX, unless such organization has entered into a memorandum of understanding, approved by the Secretary, with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located (hereinafter in this section referred to as the 'Staate agency') for the purpose of delineating the relationship between the organization and the State agency and of providing for the exchange of data or information, administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.

"(2) The requirement of paragraph (1) may be waived by the Secretary if (A) the State agency indicates to the Secretary that it does not wish to enter into a memorandum of understanding with the organization involved, or (B) the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the organization involved.

"(b)(1) The State agency may request a Professional Standards Review Organization which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions under this part.

"(2) If the agency and the organization cannot reach agreement regarding the inclusion of any such requested specification, the Secretary shall review such specification and shall require that the specification be included in the memorandum if the Secretary determines that such specification of goals or methods (A) is consistent with the functions of the organization under this part and with the provisions of title XIX and the State's plan approved under such title, and (B) does not seriously impact on the effectiveness and uniformity of the organization's review of health care services paid for under title XVIII and title XIX of this Act.

"(c) Notwithstanding any other provision of this Act, the State agency may contract with any Professional Standards Review Organization located in the State for the performance of review responsibilities in addition to those performed pursuant to this part (and the cost of performance of such additional responsibilities is reimbursable as an expense of the State agency under section 1903(a)) if—

"(1) the State agency formally requests the performance of such additional responsibilities, and

"(2) the performance of such additional responsibilities is not inconsistent with this part and is provided for in an amendment to the State's plan which is approved by the Secretary under title XIX.

"(d)(1) Each State agency may monitor the performance of review responsibilities by Professional Standards Review Organizations located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with such plan are reimbursable as an expense of the State agency under section 1903(a).

"(2) A monitoring plan developed and approved under paragraph (1) may include a specification of performance criteria for judging the effectiveness of the review performance of the Professional Standards Review Organizations. If the State agency and the Professional Standards Review Organizations cannot reach agreement regarding such criteria, the Secretary shall assist the agency and organizations in resolving the matters in dispute.

"(3)(A) Whenever a State agency monitoring the performance of review responsibilities by a Professional Standards Review Organization under a plan developed and approved under paragraph (1) submits to the Secretary reasonable documentation that the review determinations of such organization have caused an unreasonable and detrimental impact either on total State expenditures under title XIX or on the quality of care received by individuals under the State's plan approved under such title, and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, temporarily suspend such organization's authority in whole or in part under section 1158(c) to make conclusive determinations for purposes of payment under title XIX (and he may suspend such authority for purposes of payment under title XVIII) pending a reevaluation of such organization's performance of the responsibilities involved and any appropriate action the Secretary may take as a result of such reevaluation.

"(B) The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof, and shall notify the appropriate committees of the United States House of Representatives and the Senate of any such documentation submitted and the actions taken.

"(e)(1) The Secretary shall in a timely manner establish procedures and mechanisms to govern his relationships with State agencies under this part (specifically including his relationships with such agencies in connecting with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation

by the Secretary with State agency representatives and representatives of Professional Standards Review Organizations regarding relationships between such agencies and such organizations (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern, and such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a Professional Standards Review Organization located within its State.

"(2) Each Professional Standards Review Organization shall provide to the State agency for the State in which it is located, upon request, data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and such other data or information as the Secretary authorizes to be disclosed.".

(3)(A) Section 1155(e)(1) of such Act is amended by inserting "(other than a skilled nursing facility, as defined in section 1861(j))" after "the review committees of a hospital or other operating health care facility or organization".

(B) Section 1155(a) of such Act is amended—

(i) by inserting "(except as provided in paragraph (7))" in paragraph (1) after "institutional and noninstitutional providers of health care services"; and

(ii) by inserting after paragraph (6) the following new paragraph:

"(7) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1) only if the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions.".

(e) Section 1160(b)(1) of such Act is amended by striking out "practitioner or provider" each time it appears therein and inserting in lieu thereof "health care practitioner or hospital, or other health care facility, agency, or organization".

(f) Section 1163(a)(2) of such Act is amended to read as follows:

"(2) Members of the Council shall be appointed for a term of three years, except that of the members appointed in 1979, four shall be appointed for a term of only two years, and three for a term of only only one year. Members of the Council shall be eligible for reappointment.".

(g) Section 1163 of such Act is amended by striking out subsection (f).

(h) Section 1166 of such Act is amended—

(1) by striking out "or (2)" in subsection (a) and inserting in lieu thereof ", (2)";

(2) by inserting the following immediately before the period at the end of subsection (a): ", or (3) in accordance with subsection (b)";

(3) by redesignating subsection (b) as subsection (c);

(4) by inserting the following new subsection immediately after subsection (a):

"(b) A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information—

"(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such Organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse;

"(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such Organization, and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such Organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any data and information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information."; and

(5) by inserting after subsection (c) (as so redesignated) the following new subsection:

"(d) No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the National Professional Standards Review Council shall be subject to subpena or discovery proceedings in a civil action.".

(i) Section 1167 of such Act is amended by adding the following new subsection at the end thereof:

"(d) The Secretary shall make payment to a Professional Standards Review Organization, whether conditionally designated or qualified, or to any member or employee thereof, or to any person who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member or employee related to the performance of any duty or function of such organization, member or employee (as described in section 1155).".

(j) Section 1168 of such Act is amended by adding at the end thereof the following new sentence: "The Secretary shall make payments to Professional Standards Review Organizations (whether designated on a conditional basis or otherwise) from funds described in the first sentence of this section (without any requirement for the contribution of funds by any State or political subdivision thereof) for expenses incurred in the performance of duties by such Oganizations.".

(k) Part B of title XI of such Act (as amended by subsection (d)(2)(D) of this section) is further amended by adding after section 1171 the following new section:

"ANNUAL REPORTS

"SEC. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

"(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all Professional Standards Review Organizations participating in the program;

"(2) the number of health care institutions and practitioners whose services are subject to review by Professional Standards Review Organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

"(3) services determined, in accordance with the provisions of this part, to have been (A) medically unnecessary, (B) furnished in an inappropriate setting, or (C) deficient in quality;

"(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

"(5) the total costs incurred under titles V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

"(6) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of Professional Standards Review Organizations;

"(7) the progress being made among Professional Standards Review Organizations in adopting and implementing the ambulatory care review methodologies developed under section 1155(g)(1);

"(8) the results of program evaluation activities, including the operation of data collection systems and the status of Professional Standards Review Organization data policy and implementation;

"(9) the extent to which Professional Standards Review Organizations are performing reviews of services for other governmental or private health insurance programs; and

"(10) recommendations for legislative changes.".

2. On page 27, insert after line 7 the following new subsection:

(l)(1) Part A of title XI of such Act (as amended by section 3(a) of this Act) is amended by adding after section 1124 the following new section:

"DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE MEDICAL RECORDS

"SEC. 1125. (a)(1) Notwithstanding any other provision of this Act except paragraph (2) of this subsection, no officer, employee, or agent of the United States, or any office, agency, or department thereof, or any Professional Standards Review Organization or any person acting or purporting to act on behalf of such Organization, may inspect, acquire, or require the disclosure of, for any reason whatever, any individually identifiable medical record of a patient, unless the patient has authorized such inspection, acquisition, or disclosure in accordance with subsection (b).

"(2) The prohibition of paragraph (1) shall not apply to the inspection, acquisition, or disclosure of an individually identifiable medical record relating to medical care which is or was paid for (in whole or in part) under title V, XVIII, or XIX of this Act, if such inspection, acquisition, or disclosure (A) is by a Professional Standards Review Organization, or any person acting or purporting to act on behalf of such Organization, for the purpose of performing utilization review under part B of this title with respect to such medical care, or (B) is for the purpose of auditing for, investigating, or prosecuting fraud and abuse in the provision of, or payment for, such medical care.

"(b) A patient authorizes an inspection, acquisition, or disclosure of an individually identifiable medical record for purposes of subsection (a) only if, in a signed and dated statement, he—

"(1) authorizes the inspection, acquisition, or disclosure for a specific period of time;

"(2) identifies the medical records authorized to be inspected, acquired, or disclosed;

"(3) specifies the purposes for which the record may be inspected, acquired, or disclosed; and

"(4) specifies the agencies which may inspect or acquire the record or to which the record may be disclosed.

"(c) Any person who violates subsection (a), upon conviction, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.

"(d) In addition to any other remedy contained in this Act or otherwise available, injunctive relief shall be available to any person aggrieved by a violation or threatened violation of this section.

"(e) The provisions of subsection (a) supersede any other law or regulation of the United States which grants, or appears to grant, power or authority to any person to violate subsection (a), except those statutes which are enacted after the date of enactment of this section and which specifically refer to this section.

"(f) For the purposes of this section, the term 'individually identifiable medical record' means data or information that relates to the medical, dental, or mental condition or treatment of an individual and that is in a form which either identifies the individual or permits identification of the individual through means (whether direct or indirect) available to the public.".

(2) After taking into consideration the recommendations contained in the final report of the Privacy Protection Study Commission (established under section 5 of the Privacy Act of 1974), the Secretary of Health, Education, and Welfare shall prepare and submit, not later than three months after the date such Commission submits its final report, to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and to the Committee on Human Resources and the Committee on Finance of the Senate a report containing specific recommendations (including draft legislation) for the timely development and implementation of appropriate procedures (including use of detailed written consent forms) in order to (A) maintain the confidentiality of individually identifiable medical records (whether they relate to medical care provided directly by, or through the financial assistance of, the Federal Government or not), and (B) prevent the unwarranted inspection by, and disclosure to, Federal officers, employees, and agents and Professional Standards Review Organizations of such records.

3. On page 27, strike out line 8 and all that follows through the end of the bill and insert in lieu thereof the following:

(m) (1) Title XI of such Act (as amended by subsections (d) (2) (D) and (k) of this section) is further amended by adding after section 1172 the following new section:

"MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCCLUDED IN THE PROFESSIONAL STANDARDS PROGRAM

"SEC. 1173. For purposes of applying this part (except sections 1155(c) and 1163) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.".

(2) The second sentence of section 1101(a)(1) of such Act is amended by inserting "and in part B of this title" after "title V".

(n) Section 1861(w)(2) of such Act is amended by inserting "part B of this title or under" immediately after "entitled to have payment made for such services under".

(o) Section 1167 of such Act is amended—

(1) by inserting "or to any Statewide Professional Standards Review Council" in subsection (a) after "Professional Standards Review Organization";

(2) by inserting "or such Council" in subsection (a) after "such Organization";

(3) by inserting "or of any Statewide Professional Standards Review Council" in subsection (b)(1) after "Professional Standards Review Organization";

(4) by inserting "or council" in subsection (b)(1) after "organization";

(5) by inserting "or of Statewide Professional Standards Review Councils" in subsection (b)(1) after "Review Organizations"; and

(6) by inserting "AND STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS" in the heading of the section after "PROFESSIONAL STANDING REVIEW ORGANIZATIONS".

(p)(1) Section 1152(b)(1)(A) of such Act is amended by striking out "subsection (c)(i)" and inserting in lieu thereof "subsection (c)(1)".

(2) Section 1155(a)(1) of such Act is amended by striking out "(subject to the provisions of subsection (g))" in the matter preceding subparagraph (A).

(3) Section 1160(b)(1) of such Act is amended by inserting "or" after "permanently" in the matter following subparagraph (B).

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 6. Part A of title XI of the Social Security Act is amended by inserting after section 1125 (added by section 5(l)(1) of this Act) the following new section:

"ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

"SEC. 1126. (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other func-

tion authorized by law with respect to any program authorized under section 226, titles V, XVIII, or XIX or part B of this title of this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

"(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found, or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue on order requirin such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General may be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title relating to classification and General Schedule pay rates.

"(c)(1) Except as provided in paragraph (2), any employee or officer of the General Accounting Office who discloses a personal medical record (defined in paragraph (3)) to any person, other than an employee or officer of such Office whose official duties require disclosure of such information, shall be fined not more than $1,000 or imprisoned for not more than six months, or both, and charged the costs of prosecution.

"(2) An employee or officer of the General Accounting Office who discloses a personal medical record to a Federal or State agency recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse shall not be subject to the penalties of paragraph (1) if the Comptroller General has determined before the disclosure of such record that the record reveals evidence of fraud or abuse.

"(3) For the purposes of this section, the term 'personal medical record' means data or information—

"(A) relating to the medical or mental condition or treatment of any individual;

"(B) acquired by any employee or officer of the General Accounting Office in the course of any audit, investigation, examination, analysis, review, evaluation, or other fuction authorized by law with respect to any program authorized under section 226, title V, XVIII, or XIX, or part B of this title of this Act; and

"(C) in a form which can be associated with, or otherwise identify, directly or indirectly, the individual described in subparagraph (A).

"(d) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.".

SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 7. (a) Section 1862 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(e)(1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the program under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

"(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

"(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

"(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare

fully and currently informed with respect to any actions taken in response to such request.".

(b) Section 1902(a) of such Act (as amended by sections 2(b) and 3(c) of this Act) is amended—

(1) by striking out "and" at the end of paragraph (37);

(2) by striking out the period at the end of paragraph (38) and inserting in lieu thereof "; and "; and

(3) by inserting after paragraph (38) the following new paragraph:

"(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of a State plan approved under title XIX is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in its plan under this title for not less than the period specified in such notice, and no payment may be made under its plan with respect to any items or service furnished by such physician or practitioner during the period of the suspension under this title.".

(c) Section 1902 of such Act is amended by adding after subsection (f) the following new subsection:

"(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in an State plan approved under this title and of the prohibition under such subsection of payment for items or services furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of a State plan approved under title XIX such plan submits a request to the Secretary for such waiver and if the Secretary approves such request.".

(d) Section 332(c) of the Public Health Service Act (relating to considerations in the designation of health manpower shortage areas) (as added by section 407 of the Health Professions Educational Assistance Act of 1976) is amended by inserting after paragraph (2) the following new paragraph:

"(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.".

(e)(1) The amendments made by this section shall apply with respect to determinations and designations made on and after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall become effective on October 1, 1977.

DISCLOSURE OF PROVIDERS OF OWNERS AND CERTAIN OTHER INDIVIDUALS CONVICTED OF CERTAIN OFFENSES

SEC. 8. (a) Part A of title XI of the Social Security Act is amended by inserting after section 1126 (added by section 6 of this Act) the following new section:

"DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

"SEC. 1127. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

"(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

"(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health, Education, and Welfare of the receipt from any institution, organization, or agency of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

"(b) For the purposes of this section, the term 'managing employee' means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.".

(b)(1) Section 1866(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as de-

fined in section 1127(b)) of such provider, is a person described in section 1127(a).".

(2) Section 1866(b)(2) of such Act is amended by inserting before the period at the end thereof the following: ", or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1127(a)".

(c) Section 1903 of such Act is amended by adding after subsection (m) the following new subsection:

"(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1127(b)) of such institution, organization, or agency, is a person described in section 1127(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under subsection (j) of this section); and notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1127(a) at the time such contract or agreement was entered into or such approval was given.".

(d) Section 2002(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(15) Any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under the program established by this title, or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1127(b)) of such provider, is a person described in section 1127(a), and may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1127(a) at the time the contract or arrangement was entered into or the approval was given.".

(e) The amendments made by this section shall apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month beginning after the date of the enactment of this Act.

FEDERAL ACCESS TO RECORDS

SEC. 9. Section 1902(a)(27)(B) of the Social Security Act is amended by inserting "or the Secretary" after "State agency" each place it appears.

CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

SEC. 10. (a) Section 1903(a)(3)(B) of the Social Security Act is amended by striking out "notice to each individual who is furnished services covered by the plan of the specific services so covered" and inserting in lieu thereof "notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered".

(b) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after the date of the enactment of this Act.

RESTRICTION OF FEDERAL MEDICAID PAYMENTS

SEC. 11. (a) Section 1903 of the Social Security Act is amended by adding after subsection (n) (added by section 8(c) of this Act) the following new subsection:

"(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.".

(b) The amendment made by subsection (a) shall apply with respect to medical assistance provided under a State plan approved under title XIX of the Social Security Act, on and after January 1, 1978.

STUDY AND REVIEW OF MEDICARE CLAIMS PROCESSING

SEC. 12. The Comptroller General of the United States shall conduct a comprehensive study and review of the administrative structure established for the processing of claims under title XVIII of the Social Security Act, for the purpose of determining whether and to what extent more efficient claims administration under such title could be achieved—

(1) by reducing the number of participating intermediaries and carriers;

(2) by making a single organization responsible for the processing of claims, under both part A and part B of such title, in a particular geographic area;

(3) by providing for the performance of claims processing functions on the basis of a prospective fixed price;

(4) by providing incentive payments for the most efficient organizations; or

(5) by other modifications in such structure and related procedures.

The Comptroller General shall submit to the Congress no later than July 1, 1979, a complete report setting forth the results of such study and review, together with his findings and his recommendations with respect thereto.

ABOLITION OF PROGRAM REVIEW TEAMS UNDER MEDICARE

SEC. 13. (a) Section 1862(d) of the Social Security Act is amended by striking out paragraph (4).

(b)(1) Section 1862(d)(1)(B) of such Act is amended by striking out ", with the concurrence of the appropriate program review team appointed pursuant to paragraph (4),".

(2) Section 1862(d)(1)(C) of such Act is amended to read as follows:

"(C) has furnished services or supplies which are determined by the Secretary, on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title), to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.".

(3) Clause (F) of section 1866(b)(2) of such Act is amended to read as follows: "(F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care".

(4) Section 1157 of such Act is amended by striking out the last sentence.

(c) The amendments made by this section shall take effect on the date of the enactment of this Act.

AMENDMENTS RELATING TO FISCAL INTERMEDIARIES

SEC. 14. (a) Section 1816 of the Social Security Act is amended—

(1) by inserting "(and to providers assigned to such agency or organization under subsection (e))" in the first sentence of subsection (a) after "to such providers" the second and third times it appears;

(2) by amending subsection (b) to read as follows: "(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

"(1) he finds—

"(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

"(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

"(2) such agency or organization agrees—

"(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

"(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.";

(3) by inserting "after applying the standards, criteria, and procedures developed under subsection (f) and" in subsection (e)(2) before "after reasonable notice";

(4) by redesignating subsections (e), (f), and (g) as subsections (g), (h), and (i), respectively; and

(5) by inserting after subsection (d) the following new subsections:

"(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

"(2) Notwithstanding subsections (a) and (d), the Secretary may designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

"(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider or services to other than the agency or organization nominated by the

provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or organization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

"(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

"(f) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services.".

(b) The Secretary of Health, Education, and Welfare shall develop the standards, criteria, and procedures described in subsection (f) of section 1816 of the Social Security Act (as added by subsection (a)(5) not later than October 1, 1978.

(c) The amendment made by paragraphs (2) and (3) of subsection (a) to the extent that they require application of standards, criteria, and procedures developed under section 1816(f) of the Social Security Act shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

(d) Except as provided in subsection (c), the amendment made by subsection (a)(2) shall apply to agreements entered into or renewed on or after the date of enactment of this Act.

DISCLOSURE BY PROVIDERS OF THE HIRING OF CERTAIN FORMER EMPLOYEES OF FISCAL INTERMEDIARIES

SEC. 15. (a) Section 1866(a)(1) of the Social Security Act is amended—

(1) by striking out the period at the end of subparagraph (C) and inserting in lieu thereof ", and"; and

(2) by inserting after subparagraph (C) the following new subparagraph:

"(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.".

(b) The amendments made by subsection (a) shall apply with respect to agreements entered into or renewed on and after the date of enactment of this Act.

PAYMENT FOR DURABLE MEDICAL EQUIPMENT

SEC. 16. (a) Section 1833(f) of the Social Security Act is amended to read as follows:

"(f)(1) In the case of durable medical equipment to be furnished an individual as described in section 1861(s)(6), the Secretary shall determine, on the basis of such medical and other evidence as he finds appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants a presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it.

"(2) With respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

"(3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medi-

cal equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible.

"(4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individauls entitled to benefits under this title on a lease-purchase basis whenever possible.".

(b) The amendment made by subsection (a) shall apply with respect to durable medical equipment purchased or rented on or after October 1, 1977.

FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

SEC. 17. (a) Section 1903(a) of the Social Security Act (as amended by section2(b)(2) of this Act) is amended by redesignating paragraph (7) as paragraph (8) and by inserting after paragraph (6) the following new paragraph:

"(7) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (p)); plus".

(b) Section 1903(b) of such Act is amended by inserting after paragraph (2) the following new paragraph:

"(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(7) may not exceed the higher of—

"(A) $125,000, or

"(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.".

(c) Section 1903 of such Act is further amended by inserting after subsection (o) (added by section 11(a) of this Act) the following new subsection:

"(p) For the purposes of this section, the term 'State medicaid fraud control unit' means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

"(1) The entity is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

"(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

"(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

"(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

"(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments made under the State plan to health care facilities and discovered by the entity in carrying out its activities.

"(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

"(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.".

(d)(1) The amendment made by subsection (a) shall apply with respect to calendar quarters beginning after September 30, 1977.

(2) The Secretary of Health, Education, and Welfare shall establish such regulations, not later than ninety days after the date of enactment of this Act, as are necessary to carry out the amendments made by this section.

REPORT ON HOME HEALTH AND OTHER IN-HOME SERVICES

SEC. 18. (a) Not later than one year after the date of enactment of this Act, the Secretary of Health, Education, and Welfare shall submit to the appropriate committees of the Congress a report analyzing, evaluating, and making recommendations with respect to, all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act.

(b) Such report shall include an evaluation of the coordination of such services provided under different titles, and shall also include recommendations for changes in regulations and legislation with respect to—

(1) the scope and definition of such services provided under such titles;

(2) the requirements for an individual to be eligible to receive such services under such titles;

(3) the standards for certification of providers of such services under such titles and (as appropriate) the uniformity of such standards for the programs under the different titles;

(4) procedures for control of utilization and assurance of quality of such services under such titles, including (as appropriate) the licensing and accreditation of agencies providing such services, a certification of need program with respect to the offering of such services, and the development and use of norms and standards for review of the utilization and quality of such services;

(5) methods of reimbursement for such services, including (A) methods of comparing costs incurred by providers of such services in order to determine the reasonableness of such costs, and (B) methods which provide for more uniform reimbursement procedures under titles XVIII and XIX of the Social Security Act; and

(6) the prevention of fraud and abuse in the delivery of such services under such titles,

the reasons for such recommendations, an analysis of the impact of implementing such recommendations on the cost of such services and the demand for such services, and the methods of financing any recommended increased provision of such services under such titles.

(c) In developing the report the Secretary shall consult with professional organizations, experts, and individual health professionals in the field of home health and other in-home services and with providers, private insurers, and consumers of such services.

ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS FOR DIFFERENT TYPES OF HEALTH SERVICES FACILITIES AND ORGANIZATIONS; MAKING OF REPORTS UNDER MEDICARE AND MEDICAID PROGRAMS IN ACCORDANCE WITH SUCH SYSTEMS

SEC. 19. (a) Part A of title XI of this Social Security Act is amended by inserting after section 1120 the following new section:

"UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

"SEC. 1121. (a) For the purposes of reporting the cost of services provided by, of planing, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

"(1) The aggregate cost of operation and the aggregate volume of services.

"(2) The costs and volume of services for various functional accounts and subaccounts.

"(3) Rates, by category of patient and class of purchaser.

"(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

"(5) Discharge and bill data.

The uniform reporting system for a type of health services facility or organization shall provide for apropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act.

"(b) The Secretary shall—

"(1) monitor the operation of the systems established under subsection (a);

"(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

"(3) periodically revise such systems to improve their effectiveness and diminish their cost.

"(c) The Secretary shall provide information obtained through use of the uniform reporting system described in subsection (a) in a useful maner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and develompent agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.".

(b)(1) Section 1861(v)(1) of the Social Security Act is amended by adding after subparagraph (E) the following new subparagraph:

"(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.".

(2) Section 1902(a) of such Act (as amended by sections 2(b), 3(c), and 7(b) of this Act) is amended—

(A) by striking out "and" at the end of paragraph (38);

(B) by striking out the period at the end of paragraph (39) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (39) the following new paragraph:

"(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization.".

(c)(1) The Secretary of Health, Education, and Welfare shall establish the systems described in section 1121(a) of the Social Security Act (added by subsection (a) of this section) only after consultation with interested parties and—

(A) for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one-year period, and

(B) for other types of health services facilities and organizations, not later than the end of the two-year period, beginning on the date of enactment of this Act.

(2)(A) The amendments made by subsection (b) shall apply, with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under section 1121(a) of the Social Security Act) for that type of health services facility.

(B) The amendments made by subsection (b) shall apply, with respect to the operation of a health services facility or organization which is neither a hospital, a skilled nursing facility, nor an intermediate care facility, on and after the first day of its first fiscal year which begins after such date as the Secretary of Health, Education, and Welfare determines to be appropriate for the implementation of the reporting requirement for that type of facility or organization.

(C) Except as provided in subparagraphs (A) and (B), the amendments made by subsection (b)(2) shall apply, with respect to State plans approved under title XIX of the Social Security Act, on and after October 1, 1977.

I. Purpose and Background of the Bill

In recent years, numerous hearings, studies, and investigations undertaken by your committee, other committees of the Congress, the General Accounting Office, and other Federal and State agencies have demonstrated that there exist, to a disturbing degree, fraudulent and abusive practices associated with the provision of health services financed by the medicare and medicaid programs. The disclosures to date have focused on a broad range of improper activities which are not restricted to one particular class of providers or treatment settings. In whatever form it is found, however, fraud in these health care financing programs adversely impacts on all Americans. It

cheats taxpayers who must ultimately bear the financial burden of misuse of funds in any government-sponsored program. It diverts from those most in need, the nation's elderly and poor, scarce program dollars that were intended to provide vitally needed quality health services. The wasting of program funds through fraud also further erodes the financial stability of those state and local governments whose budgets are already overextended and who must commit an ever-increasing portion of their financial resources to fulfill the obligations of their medical assistance programs.. In addition to these adverse financial consequences, the activities of those who seek to defraud these programs unfairly call into question the honesty and integrity of the vast majority of practitioners and health care institutions.

In its review of the operation of the medicare program, your committee has not been satisfied with the rate of development of the nationwide peer review system mandated by the Social Security Amendments of 1972. Although there is now almost universal acceptance of the concept of physician-sponsored Professional Standards Review Organizations charged with the responsibility of monitoring the quality and necessity of health care paid for by government-financed health programs, full implementation of the PSRO program has been undesirably slow.

Moreover, since issues of medical necessity and quality of care may be present in cases of possible program abuse (as distinct from criminal fraud), PSRO's can be a valuable resource for the exercise of the professional medical judgment that may need to be made in certain of such cases. Your committee believes that every effort must be made to encourage the rapid implementation of the PSRO program. To achieve this end, H.R. 3 includes several provisions making modifications in the administrative structure of the program to enhance the capacity of individual PSRO's to effectively review matters of quality and necessity.

Your committee finds the disclosures of fraud and abuse and waste in medicare and medicaid particularly alarming in view of the considerable discussion of expansion of the Federal role in the provision of health insurance for additional groups of Americans. It is your committee's belief that these serious problems with our existing federal health programs must be addressed prior to actual congressional consideration of the further expansion of the federal role in the financing of health care.

On March 3 and 7, hearings were held on this legislation by your committee's Subcommittee on Health. These hearings were held jointly with the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce, since the medicaid program is now within that committee's jurisdiction. The Subcommittee on Health considered this legislation in executive session on March 30, 31, April 6, and May 5, and the full Committee on Ways and Means considered the bill and ordered it reported on June 2. The legislation that has been reported by your committee is a product of close consultation and cooperation throughout the stages of its development with the Committee on Interstate and Foreign Commerce. After consideration of a series of changes recommended by each committee,

both committees are recommending very similar committee amendments in reporting the bill to the full House.

In endorsing the legislation with strengthening amendments, however, your committee believes that it should be clearly understood that this legislation will not eliminate fraud and abuse. Legislation alone cannot do that. Improved program management, with the institution of efforts specifically directed to combating fraud and abuse, and more widespread and effective peer review activity will be necessary. H.R. 3 is only a step toward the achievement of that goal. It is designed to eliminate weaknesses in existing law that might encourage fraudulent or abusive practices, to provide the appropriate governmental agencies with additional tools to combat these problems and to address certain policies and practices in the administration of medicare and medicaid that have led to an inefficient use of program monies.

II. Summary of the Bill

As reported, the provisions of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, are focused on five major areas: Strengthened program penalty sanctions, increased disclosure of information, needed improvements in the Professional Standards Review program, administrative reform, and technical revision. The summary presented below briefly outlines the principal features of the bill as reported under the general headings referred to above:

PROGRAM PENALTY SANCTIONS

1. Your committee's bill modifies the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors are to become felonies. Penalties are to be increased to a maximum $25,000 fine, up to five years imprisonment, or both. The types of financial arrangements and conduct to be classified as illegal have been clarified. In addition, States will now be permitted to suspend the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty presently provided under existing law for conviction of such individuals is retained, as is the misdemeanor penalty for the conviction of a beneficiary under the medicare program. The bill also requires the Health, Education, and Welfare Inspector General to include in his annual report an evaluation of the effort of the Department of Justice in the investigation and prosecution of fraud in the medicare and medicaid programs and his recommendations for improvement of that effort. (Section 4)

2. The bill requires the Secretary of Health, Education, and Welfare to suspend, for such period as he deems appropriate, from participation under medicare and medicaid, an individual practitioner who has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. When the Secretary suspends an individual, he must also notify the appropriate State licensing authorities, requesting that investigation be made and sanctions invoked in accordance with the State's law and public policy. (Section 7)

DISCLOSURE OF INFORMATION

1 (a) Your committee's bill requires, as a condition of participation or certification in either medicare, medicaid or the maternal and child health program, the annual disclosure to the Secretary or the appropriate State agency by the participating entity of the identity of any person who has a five percent or more ownership interest in the entity. These disclosure of ownership provisions will apply to medicare and medicaid providers of services (including independent clinical laboratories and renal disease facilities), entities furnishing services for which payment may be claimed under medicaid or the maternal and child health program (but not including any individual or group of practitioners), and medicare carriers or intermediaries and medicaid fiscal agents. Providers of services would also have to disclose similar ownership information about any subcontractor, five percent or more of which is owned by the provider. (Section 3)

(b) Furthermore, the bill modifies existing medicare and medicaid provisions relating to termination of medicare provider agreements or suspension of medicaid payments to health care entities by adding a requirement that a provider must comply with a request specifically addressed to it by the Secretary or the medicaid State agency for full and complete information as to any significant business transactions between it and any subcontractors or between it and wholly-owned suppliers. Finally, in the case of subcontractors having more than $25,000 in annual business transactions with a provider, compliance would be required with similar requests related to ownership information pertaining to the subcontractor. (Section 3)

2. The bill requires all institutional providers of services, or other agencies, institutions, or organizations, as a condition of participation or certification in medicare, medicaid or the social services programs under Title XX of the Social Security Act to disclose, in the application for participation or certification, the names of owners, officers, directors, agents, or managing employees who have been convicted of fraud against the medicare, medicaid, or State social service grant programs. Where an application contains the name of any such previously convicted individual, the Secretary or the State agency can refuse to enter into an agreement or refuse to contract with the applicant. The Inspector General of the Department of Health, Education, and Welfare must be informed of the receipt of any such applications and of any action taken on them. (Section 8)

3. The bill authorizes the Comptroller General of the United States to sign and issue subpenas in order to obtain necessary information and facilitate review of Social Security Act health programs. The Comptroller General will also be authorized, upon resistance or refusal by an individual to obey a subpena, to request a court order requiring compliance with the subpena. The bill would impose criminal sanctions for unauthorized disclosure by the GAO of individually identifiable personal medical records and would protect such records from subpena or discovery proceedings in connection with a civil suit. (Section 6)

4. The bill requires any provider of services participating in medicare to promptly notify the Secretary of its employment of an individual who, at any time during the preceding year, was employed

in a managerial, accounting, auditing, or similar capacity by a medicare fiscal intermediary or carrier that services the provider. (Section 15)

5. The bill allows Federal access to the records of persons or institutions providing services under medicaid in the same manner that such access is presently provided to State agencies. (Section 9)

PROFESSIONAL STANDARDS REVIEW

Your committee's bill includes several provisions designed to clarify the nature and scope of PSRO review responsibilities, to enhance the capacity of PSRO's to more effectively perform reviews of the necessity and appropriateness of services, and to improve the administration and coordination of review activities so as to assure that program funds are properly expended. Thus, section 5 of the bill provides:

(1) for the termination of other duplicative review activities when the Secretary determines that a PSRO is competent to perform its review responsibilities; that the determinations of PSRO's so recognized by the Secretary with respect to the necessity and appropriateness of care are conclusive for purposes of program payment; and that the role of the State in the process of establishing and evaluating PSRO review of services provided through the medicaid program will be increased and made more specific;

(2) that a PSRO may be conditionally designated for a period not to exceed 48 months (with authority for the Secretary to extend the period for an additional 24 months where warranted by unusual circumstances); and that PSRO's must assume review responsibilities for institutional services during this period;

(3) for the Secretary to develop ambulatory care review methodologies for use by PSRO's and to make such methodologies available within 2 years; to require a PSRO, where he finds it is capable of undertaking ambulatory care review, to undertake such review no later than 2 years after it becomes fully operational; and to give priority to requests by PSRO's to review services in "shared health facilities";

(4) that the Federal Government may assume the defense costs incurred by a PSRO in a liability suit related to the performance of its functions;

(5) for the disclosure of information with respect to evidence of fraud to designated Federal and State law enforcement agencies (with a prohibition against access to PSRO records in the case of subpena or discovery proceedings in a civil action), and for the disclosure of aggregate statistical data to Federal and State health planning agencies;

(6) for the annual submission to the Congress by the Secretary of a comprehensive report on the administration, cost, and impact of the PSRO program;

(7) for a prohibition against any Federal official or PSRO inspecting, acquiring, or requiring the disclosure of any individually identifiable medical record without the consent of

the patient. This prohibition would not apply to medical records relating to medical care furnished under the Social Security Act if such inspection, acquisition or disclosure was either done by a PSRO in its review work, or was done for the purpose of investigating fraud and abuse. The Department of HEW would also be required to submit its legislative recommendations to the Congress as to the appropriate procedure for maintaining the confidentiality of individual medical records. These recommendations shall be made after taking into consideration the final report of the Privacy Protection Study Commission and shall be submitted to the Congress no later than 90 days after the Privacy Commission's report is issued; and

(8) for several clarifying administrative and technical changes designed to enhance a PSRO's operational capacity. (Section 5)

ADMINISTRATIVE REFORM

1. Your committee's bill authorizes the Secretary to assign and reassign providers to available intermediaries, after taking into account any preferences expressed by the providers and after applying objective performance standards to the original nominee of the provider prior to making a reassignment. Any assignment action he takes must be based on a finding that it will result in more efficient and effective administration of the program. Before making any assignment or reassignment that is not in accord with the provider's choice, the Secretary must furnish to the provider and its chosen intermediary a full explanation of his findings with respect to efficiency and effectiveness and provide an appropriate opportunity for a hearing, which is subject to judicial review.

The Secretary is also authorized to designate regional intermediaries or a national intermediary with respect to a class of providers (e.g., home health agencies) where he determines that, after applying objective performance standards to agencies or organizations that would be adversely affected, such designation will result in more efficient and effective administration of the program. In a similar manner to that mentioned above, this authority to designate with respect to a class of providers is subject to a requirement that the Secretary fully explain to the affected parties his findings with respect to efficiency and effectiveness and provide an appropriate opportunity for a hearing which is subject to judicial review. (Section 14)

2. The bill requires the Secretary to establish for each of the different types of health services institutions a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider. (Section 19)

3. The bill repeals the program review team provisions of present law. The functions formerly performed by such teams with respect to the quality and utilization of services will be performed by Professional Standards Review Organizations. (Section 13)

4. The bill would encourage each State to establish an office separate from the medicaid program agency to prepare and prosecute cases of suspected fraud and abuse in the program by providing for 90 percent Federal matching funds for expenditures to establish and operate State medicaid fraud control units. (Section 17)

5. The bill also requires States to make provision in their State medicaid plan for claims payment procedures which ensure that 90 percent of the bills submitted by eligible noninstitutionally-based providers will be reimbursed within 30 days, and 99 percent within 60 days. The State would not be cited for noncompliance if the Secretary found the State was acting in good faith to achieve this goal. (Section 2)

6. The bill directs the Comptroller General to conduct a comprehensive review of the administrative structure for the processing of medicare claims. (Section 12)

7. The bill requires the Secretary of Health, Education, and Welfare to report to the Congress within 12 months after enactment of this legislation with an analysis and recommendations relating to all aspects (including the availability, administration, provision, reimbursement procedures and cost) of the delivery of home health services under medicare, medicaid and the title XX social services program. (Section 18)

TECHNICAL REVISION

1. Your committee's bill clarifies existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against the use of "factoring" arrangements in connection with the payment of provider claims by the medicare and medicaid programs. (Section 2)

2. The bill modifies the provisions of existing law related to the rental or purchase of durable medical equipment to mandate that the Secretary require the purchase of such equipment where purchase will be less costly than extended rental payments. (Section 16)

3. The bill increases individual state's incentives to adopt a computerized medicaid claims processing and information retrieval system by modifying one current requirement for higher Federal matching funds for the development and operation of this system. The bill would require such systems to provide explanation of benefits information to only a sample group of medicaid recipients rather than to each recipient as is currently required. (Section 10)

4. The bill would preclude Federal matching of State medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for medicaid. (Section 11)

III. General Statement

EXPLANATION, JUSTIFICATION, AND COMPARISON WITH PRESENT LAW

Prohibition Against Assignment by Physicians and Others of Claims for Services; Claims Payment Procedures for Medicaid Program (Section 2)

Your Committee's bill would modify existing law to preclude the use of a power of attorney as a device to circumvent the existing ban on the

use of "factoring" arrangements in connection with the payment of claims by the medicare and medicaid programs. The bill further requires State medicaid programs to provide for timely claims payment procedures and provides higher Federal matching funds for a three-year period to assist States with programs of educational and technical assistance to expedite the filing and payment of claims.

In 1972, the Congress took action to stop a practice under which some physicians and other persons providing services under medicare and medicaid reassigned their medicare and medicaid receivables to other organizations or groups. Under the conditions of these reassignments, the organizations or groups purchased the receivables for a percentage of their face value, submitted claims and received payments in their name. By 1972, it had become apparent that such reassignments were a significant source of incorrect and inflated claims for services paid by medicare and medicaid. In addition, cases of fraudulent billings by collection agencies and substantial overpayments to these so-called "factoring" agencies were also found.

Congress concluded that such arrangements were not in the best interest of the government or the beneficiaries served by the medicare and medicaid programs. The Social Security Amendments of 1972, Public Law 92–603, therefore, included a prohibition against the payment for covered services to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with a facility under which the facility bills for such services.

Despite these efforts to stop factoring of medicare and medicaid bills, some practitioners and other persons have circumvented the intent of the law by use of a power of attorney. The use of a power of attorney allows the factoring company to receive the medicare or medicaid payment in the name of the physician, thus allowing the continuation of program abuses which factoring activities were shown to produce in the past.

Your committee's bill would modify existing law to preclude the use of a power of attorney as a device for reassignments of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. The bill also provides for similar prohibitions with respect to billings for care provided by institutions under medicare and medicaid. However, it would not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the agency does so pursuant to an agreement under which the compensation paid the agency for his services or for the billings or collections of payments is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. Thus, the use of billing agents by doctors and others, when the agents are paid on a basis related to the cost of doing business and not dollar amounts billed or collected, would not be precluded. The bill would not impose any limitations on the use

of billing or collection agencies for payments owed by anyone other than the medicare or medicaid programs. Nor is it your committee's intention that this provision preclude the legitimate transfer of accounts receivable from these programs by an individual or an institution upon the "sale" of the individual's practice (for example upon retirement) or as part of the sale of all the assets of an institution.

Your committee received considerable testimony indicating that undue delay in medicaid claims payments contributes to the rise of factoring arrangements as well as discourages physicians from participating in the program. The committee wishes to assure that the ban on factoring arrangements will not impose an undue hardship on medicaid practitioners. The bill therefore requires State medicaid plans to provide for claims payment procedures which ensure that 90 percent of claims for services furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of receipt; 99 percent of such claims must be paid within 60 days of receipt. State plans must further provide for procedures for prepayment and postpayment claims review. The bill permits the Secretary of Health, Education, and Welfare to waive this State plan requirement if he finds that a State has exercised good faith in trying to ensure timeliness and accuracy in its claims payment operation. Among other things the Secretary should take into account in making a waiver determination is whether the State has received an unusually high volume of claims which are not clean claims (i.e., claims for which no further written information or substantiation is required from the provider).

In many areas of the country, a significant volume of medicaid claims submitted are inadequately or incorrectly filed. The bill therefore authorizes 90 percent Federal matching from January 1978 through September 1980 for the costs attributable to the conduct of such educational and technical assistance programs for health care practitioners as the Secretary determines are likely to expedite the filing and payment of claims. Technical assistance may be provided through such means, including outreach offices, the media, and telephone systems, as the Secretary determines to be appropriate. The maximum amount of payment available to the States under this section may not exceed $1.25 million in any calendar quarter. If the aggregate amount of payment would otherwise exceed this limitation, the amount made available to each State would be proportionately reduced.

Disclosure of Ownership and Financial Information (Section 3)

Your Committee's bill would require entities (other than individual practitioners or groups of practitioners) providing services under medicare, medicaid, or the maternal and child health program to disclose certain ownership interests, as a condition of program participation. These disclosure requirements would also be applied to medicare intermediaries and carriers and medicaid fiscal agents. Disclosure of additional ownership and financial information would be required, but only when specifically requested.

Current law and program policies already require the provision of certain ownership and financial information pertaining to entities

providing services under medicare and medicaid. For example, an agreement with a provider of services under medicare may be terminated if the provider fails to furnish information necessary to validate the amount of payment claimed. In a different context, present law requires, as a medicare and medicaid condition of participation, a skilled nursing facility to disclose to the Secretary or appropriate State agency, and keep current, the name of anyone having significant ownership interest in the facility. Intermediate care facilities under medicaid are also required to disclose information on significant ownership interests.

Your Committee believes, however, that the information required under current law is often insufficient to facilitate the detection of fraudulent practices. Information now required does not provide adequate documentation on persons with significant ownership interests in more than one facility or other entity participating in medicare, medicaid, or the material and child health program. Information is not specifically required to identify persons with significant ownership interests in related companies that supply goods and services to providers or other participating entities. Authority to obtain information on financial transactions with related suppliers or with subcontractors is not clearly defined in law.

To remedy these problems, the bill would require disclosure of specified ownership information to the Secretary or the appropriate State agency, as a condition of an entity's participation, certification, or recertification under medicare, medicaid, or the maternal and child health program. Entities required to disclose would be defined as: Medicare providers of services (as defined in section 1861(u), which includes hospitals, skilled nursing facilities, and home health agencies), independent clinical laboratories, renal disease facilities, and all entities (other than individual practitioners or groups of practitioners) that claim reimbursement for services provided under medicaid or the maternal and child health program. In addition, the bill would require medicare intermediaries and carriers and medicaid fiscal agents to disclose specified ownership information as a condition of contract or agreement approval or renewal under titles XVIII and XIX.

The bill specifies that disclosing entities must supply full and complete information as to the identity of each person who:

(1) has a direct or indirect ownership interest of five percent or more in the entity,

(2) owns (in whole or part) a five percent interest in any mortgage secured by the entity,

(3) is an officer or director of the entity, if it is organized as a corporation, and

(4) is a partner in the entity, if it is organized as a partnership.

Where disclosing entities providing services under medicare or medicaid own five percent or more of a subcontractor, similar ownership information would be required to be disclosed about the subcontractor.

In addition, the bill would require, to the extent feasible, that information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of that person

in any other entity which is required to comply with disclosure requirements under the bill.

The bill would also modify the existing provisions of titles XVIII and XIX which relate to termination of medicare provider agreements or suspension of medicaid payments to health care entities (other than individual practitioners and groups of individual practitioners) by adding two additional requirements. The bill would require a provider entity to comply with specific requests addressed to it by the Secretary or the State medicaid agency for full and complete information on: (1) the ownership of any subcontractor (as defined in regulations) with whom the provider has annual business transactions of more than $25,000, and (2) any significant business transactions (as defined in regulations) between it and any subcontractor or between it and any wholly-owned supplier.

In developing regulations to define subcontractors and suppliers, the Committee intends that a distinction be made between agencies and organizations from which a provider only purchases goods and services to assist it in meeting its obligations to patients and those agencies and organizations to which a provider has actually delegated some of the duties and obligations it has directly to its patients. Although the facts and circumstances of individual situations may differ, it is contemplated under such a delineation that the relationship between a hospital and a commercial laundry would be considered to be that of a provider and its supplier, but that the relationship between a hospital and a management company with which it has contracted to administer either all or part of the day-to-day operations of the institution or the relationship between a hospital and an independent radiological service would be that of a provider and a subcontractor.

The bill specifies that the Secretary is to determine by regulation the meaning of the phrase "directly or indirectly" with respect to persons having ownership interests in disclosing entities. In directing him to do this, your Committee is acutely aware of the difficulties involved in developing this definition, particularly when the phrase "persons with ownership interests" is interpreted to mean a corporation. Institutional providers of health care often are owned by corporate entities which in turn are owned by other corporations. In order to compile accurate information on persons with ownership interests in disclosing entities, your Committee believes it is also necessary to obtain information on persons with ownership interests in these other corporations. The information to be disclosed under the bill must go beyond the listing of corporate identities unless that corporation is already subject to ownership disclosure under the statutes administered by the Securities and Exchange Commission or other Federal regulatory agencies. It is intended, at the minimum, to identify those persons with ownership interests of five percent or more in a nonpublicly held corporation that owns a disclosing entity. In addition, the Secretary may determine that it is necessary to require disclosure of persons with ownership interests in nonpublicly held corporations beyond the first level of corporate ownership where the concept of "pyramiding" of corporate structures appears to be present.

Your committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and deterring fraudulent and abusive practices within the medicare, medicaid,

and the maternal and child health programs. Your Committee does not intend, however, for these requirements to be unduly burdensome on providers and other entities to which they apply. The provisions were designed to be incorporated into the ongoing certification or contractual process. It is, therefore, expected that their implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.

Penalties for Defrauding Medicare and Medicaid (Section 4)

Your committee bill would modify the penalty provisions in existing law which relate to those persons providing services under medicare and medicaid.

Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs. Such practices as the submission of false claims, or the soliciting, offering, or acceptance of kickbacks or bribes, including rebates or a portion of fees or charges for patient referrals, are misdemeanors under present law and punishable by a maximum $10,000 fine, up to one year imprisonment, or both. In addition, the making of false statements with respect to material facts concerning the conditions of health care facilities in order to qualify for certification under medicare and medicaid is considered a misdemeanor and punishable by a maximum $2,000 fine, up to six months in prison, or both.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. Attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

Your committee's bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum $25,000 fine, up to five years imprisonment, or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

It would make subject to the penalty provisions any person who solicits or receives any remuneration (1) in return for referring an individual to a person for the furnishing, or arranging for the furnishing of, items or services; or (2) in return for purchasing, leasing, or ordering, or arranging for, or recommending the puchasing, leasing, or ordering of goods, facilities, or services. Also, any person

who offers or pays any remuneration to any person to induce such person to do similar activities would be subject to the penalty provisions.

Your committee's bill would define the term "any remuneration" broadly to encompass kickbacks, bribes, or rebates which may be made directly or indirectly, overtly or covertly, in cash or in kind (but would exclude any amount paid by an employer to an employee for employment in the provision of covered items or services).

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under medicare and medicaid, but only if such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed. The committee included this provision to ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal. In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to medicare and medicaid program costs.

In addition, the committee bill would allow States to suspend, for a period not to exceed one year, the eligibility of medicaid recipients convicted of defrauding the program. However, the misdemeanor penalty provision presently provided under existing law for conviction of such individuals would be retained (maximum fine of $10,000, up to one year imprisonment, or both) as would be the penalty for conviction of a beneficiary under the medicare program.

In its consideration of this bill, your committee has focused considerable attention on the activities of the Department of Justice to investigate and prosecute fraud in the medicare and medicaid programs. The committee believes that the Department must develop the resources to combat this complex type of criminal activity. Your committee has received a commitment from the Attorney General to strengthen departmental efforts in this area and intends to monitor those efforts quite closely. The letter of the Attorney General outlining departmental initiatives in this area follows:

OFFICE OF THE ATTORNEY GENERAL,
Washington, D.C., May 12, 1977.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am writing you again with reference to the proposal to include in H.R. 3 a mandate for the establishment of a separate and identifiable organizational unit within the Department's Criminal Division to carry out specified functions relating to investigation and prosecution of criminal violations in the programs of health insurance and medical assistance provided under the Social Security Act. As I indicated in my appearance before your Subcommittee, I fully concur in the need for vigorous investigation and prosecutions of fraudulent activities in the medicare-medicaid program. I strongly feel, however, that the aforementioned provision is unnecessary and would set an undesirable precedent by dictating in law a particular subordinate organization within the Criminal Division.

In recognition of the importance of taking effective action against medicare-medicaid abuses, we are currently taking the following steps.

1. We have within the Fraud Section of the Criminal Division a program fraud unit which coordinates Department efforts directed against program abuse and maintains regular liaison with program agencies including HEW.

2. We are currently working on preparation of a Medicaid Enforcement Manual for distribution to Assistant United States Attorneys to assist them in prosecuting medicaid-medicare cases.

3. We are meeting on a regular basis with the Inspector General and his staff of HEW in an attempt to develop strategies and enforcement priorities within medicaid-medicare areas.

4. There is a separate program fraud unit within the Public Integrity Section which focuses on situations involving corruption of government officials in the administration of programs.

5. We are attempting to identify significant cases in order to insure that ample resources are devoted to their development and prosecution.

6. Many of the larger of the United States Attorneys offices, including the Southern District of New York and Chicago, have established separate program fraud units within the district to focus on these types of offenses.

I have every intention of continuing emphasis in this area. I do respectfully recommend, however, against placing in the law the requirement of a specific organization entity for this purpose. I am afraid that other Congressional committees will feel that they must support similar organizational requirements in law for their programs to insure that such programs receive appropriate attention. A proliferation of special units would inevitably lead to confusion, lack of flexibility and be self-defeating of the purposes intended.

Sincerely,

GRIFFIN B. BELL, *Attorney General.*

In addition, your committee's bill modifies section 204(a) of Public Law 94–505, relating to the annual reports of the Health, Education and Welfare Inspector General, to require the Inspector General's report to include an evaluation of the performance of the Attorney General in the investigation and prosecuting of criminal violations relating to fraud in the medicare and medicaid programs and include any recommendations with respect to improving the performance of such activities.

Amendments Related to Professional Standards Review Organizations (Section 5)

Waiver of Other Review Requirements (Section 5(a))

Your committee's bill provides that where the Secretary finds a given Professional Standards Review Organization (PSRO) competent to perform required review functions, similar activities otherwise required by law would not apply, except to the extent specified by the Secretary.

Under present law, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under the law where he finds, on the basis of substantial evidence of

the effective performance of review and control activities by PSRO's, that the activity or activities are no longer needed for the provision of adequate review and control. The purpose of this provision was to avoid duplication of review functions. Current law does not specifically state that the waiver authority is applicable to conditionally designated organizations, although the language has been interpreted to permit such actions.

Your committee's bill would both clarify present law and simplify its application by providing that where the Secretary makes a formal determination that a given PSRO is competent to perform required review functions, the review, certification and similar activities otherwise required by law would not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. A finding by the Secretary under this subsection could be made both with respect to conditionally designated and qualified PSRO's. The provision would not affect other provisions of existing law relating to determinations with respect to conditions for eligibility to or payment of benefits (as distinct from reviews or certifications of medical necessity).

Modification of Requirements for Conditionally Designated PSRO's (Section 5(b))

Your committee's bill extends the time period for conditional designation of PSRO's and clarifies the language of present law pertaining to the duties and functions a PSRO must assume during this trial period.

Current law provides that each PSRO shall initially be designated on a trial basis for a period not to exceed two years. By the end of the period, the organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner the functions required of a PSRO with respect to institutional services in its area. When the legislation was enacted, it was anticipated that conditionally designated organizations would be able to assume review responsibilities with respect to all institutional services within a two-year period. Implementation of the program has been slower than anticipated with the major focus to date on review of inpatient hospital services. A number of conditionally designated organizations have or are approaching the end of their two-year trial period. While many are effectively performing reviews of services, they are technically not eligible for continuation of their conditional status or designation as qualified organizations.

The bill modifies the conditional designation provision of present law to provide for a conditional period not to exceed 48 months. The Secretary would be authorized to extend this period for an additional 24 months if an organization has, for reasons beyond its control, been unable to satisfactorily perform all of its required functions. The committee expects that this extension of the conditional period would be authorized only in unusual circumstances.

The bill also clarifies the requirement of present law that PSRO's must assume responsibility for review of all institutional services (including ancillary services) during the conditional period. Additionally, the bill clarifies the requirement that PSRO's must be reviewing

long-term institutional care services (subject to the provisions of section 5(d) which leave the responsibility for review of services in intermediate care facilities with the State medicaid agency unless the Secretary finds the State is not performing effective review).

Review Requirements (Section 5(c))

Your committee's bill requires the Secretary to give priority to PSRO requests to review services provided in "shared health facilities"; mandates the development of ambulatory care review methodologies for use by PSRO's; requires a PSRO to undertake ambulatory care review not later than two years after it has achieved operational status; and modifies the language in current law pertaining to physicians excluded from participation in review activities.

Under current law, a PSRO is required to review only care provided by or in institutions. It may request authority to review other kinds of health services, and the Secretary may approve the request at his option. To date, little emphasis has been given to the assumption of review responsibility by PSRO's for other kinds of health care services.

The bill would require the Secretary to give priority to requests by PSRO's to review services in "shared health facilities" with the highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. A "shared health facility" is defined as an arrangement meeting all of the following criteria:

(1) Two or more practitioners practice their professions at a common physical location;

(2) The practitioners share common space, services of supporting staff or equipment;

(3) The practitioners have a person (who may himself be a practitioner), paid on a percentage or other basis clearly unrelated to the value of the services provided, who either is in charge of or supervises substantial aspects of the operation or who makes available services of supporting staff who are not employees of such practitioners; and

(4) At least one of the practitioners receives from medicare, medicaid, and maternal and child health fee-for-service payments in excess of $5,000 for one month or $40,000 for 12 months.

The term "shared health facility" specifically excludes hospitals, skilled nursing facilities, home health agencies, federally approved health maintenance organizations, hospital cooperative shared services organizations meeting the requirements of section 501(e) of the Internal Revenue Code, or any public entities.

The definition of a "shared health facility" is designed to distinguish those types of ambulatory facilities (sometimes referred to as "Medicaid Mills") which are characterized by a high volume of services to medicaid patients (often of an excessive or unnecessary nature), and the payment of a percentage of the medicare and medicaid billings to the owner or manager of the facility, from legitimate group practice arrangements under which several practitioners render services at a common location. Since a shared health facility could evade the test of percentage arrangements, the Secretary has leeway to determine whether the payments to the owner or manager, while technically not a percentage of billings, are clearly unrelated to the

value of the services provided by such person to the facility. By requiring a facility to meet all four criteria specified in the bill, it is expected that such legitimate arrangements among practitioners would be excluded from the definition. The Committee expects, therefore, that the Department will exercise judgment in applying this definition so as to assure that legitimate group practice arrangements are not inappropriately classified.

Recent congressional hearings and reports have documented widespread instances of fraud and abuse in certain types of ambulatory facilities which have come to be known as "Medicaid Mills." The definition of shared health facilities is designed to identify these specific types of arrangements in order to facilitate PSRO review of the services furnished by such facilities. Your Committee wishes to emphasize that a PSRO is not a fraud detection organization; its role is to render professional determinations as to the medical necessity and appropriateness of services. Thus, a PSRO will be expected, where it chooses to undertake review of services furnished by "shared health facilities," to review those services for the same purposes—to judge appropriateness and quality—that it would review services provided in other health care settings.

Under current law, PSRO's may request authority review ambulatory care services, i.e., those provided in clinics or doctors' offices. However, your committee notes that reliable ambulatory care review methodologies have not as yet been developed. The bill, therefore, requires the Secretary to develop, within two years, effective ambulatory care review methodologies for use by PSRO's. The bill further directs the Secretary, where he finds a PSRO capable of undertaking ambulatory care review, to require the organization to undertake such review not later than two years after it has achieved operational status. The Committee expects that in implementing this requirement, the Secretary will exercise judgment with respect to the varying capacities of PSRO's and, where appropriate, will establish a reasonable classification of ambulatory care review activities for an organization to undertake. Such classification might include specific categories of services or specific aspects of various service categories. Your committee further notes that "ambulatory care services" are those services not rendered by or in an institution. Institutional review, including review of services provided in hospital outpatient departments or emergency rooms, is a requirement of current law and must be conducted before an organization can achieve operational status.

Under current PSRO review provisions, a physician is precluded from reviewing health services provided to a patient if he was directly or indirectly involved in providing the services. Present law further precludes review by a physician of services furnished in any institution, organization, or agency if he or any member of his family has, directly or indirectly, any financial interest in such entity.

Your committee's bill would modify these restrictions to permit greater opportunity for physician participation in PSRO review activities. Under the bill, a physician would not be permitted to review services for which he was directly responsible (rather than directly or indirectly responsible as in present law) or services in an institution in which he or a member of his family has a "significant" financial

interest (rather than "any" financial interest, as in present law.) The committee expects that in implementing this provision, HEW will employ the same definition of "significant" financial interest as is currently used in administering medicare.

The bill further provides that arrangements with PSRO's for reimbursement of the costs of review activities are to be made in a manner similar to that provided for medicare intermediaries (which includes provision for advances of funds and payment of administrative costs).

Conclusive Determinations for Payment (Section 5(d))

Your committee's bill provides that where a PSRO has been found competent by the Secretary and is performing specific review functions, medical determinations made in connection with such review shall be considered conclusive on those issues for purposes of payment. The bill provides a formal role for the States in the process of establishing and evaluating PSRO review of services provided through the medicaid program. The bill also precludes delegated review in skilled nursing facilities and provides that review of intermediate care facility services will be undertaken by a PSRO only if the Secretary finds that the State is not performing effective review in these facilities.

Under present law, medicare payments and the Federal share of medicaid payments may not generally be made for health care services which a PSRO, in the proper exercise of its duties, has determined to be medically unnecessary or inappropriate. However, the committee believes that it is necessary, in order to avoid the performance of disruptive duplicative reviews by medicare and medicaid agencies, to clarify the scope of the PSRO's authority and the role of the medicaid State agencies.

Accordingly, your committee's bill provides that where a conditionally designed or a qualified PSRO has been found competent by the Secretary to assume specific review responsibilities and is performing such reviews, a determination as to quality or necessity made in connection with such review would constitute the conclusive determination on those issues for purposes of payment. (Such determinations would be subject to the hearings and appeals provisions of present law.) Medicare fiscal intermediaries and State medicaid agencies would continue to be responsible for other types of reviews and determinations relating to program eligibility, coverage of services, audit, claims payment, fraud and abuse detection, and related activities.

Your committee has received comments from a number of States expressing concern over the potential impact of PSRO determinations on State medicaid budgets. The committee has concluded that since substantial State monies are involved it is appropriate that they be given an opportunity to evaluate a PSRO's capability to efficiently and effectively perform review of medicaid services. The bill, therefore, makes provision for the participation of States in the PSRO designation process and in the ongoing monitoring of PSRO review activities.

Your committee's bill requires a PSRO to consult with the medicaid State agency in the development of its formal review plan (required as a condition for designation) and in any modification of the plan involving assumption of review responsibility for additional categories of services. The bill provides the States with an opportunity to review

and comment on the proposed conditional designation of a PSRO, the change in designation status from conditional to operational, and the assumption by the PSRO of responsibility for long-term care and ambulatory care review. Before the Secretary designates a PSRO or substantially adds to its functions, he is required to take the State's views into account. If his decision differs from the course recommended by the State, he must notify the State of the reason for his decision and allow them additional time to provide further support for their views.

The bill provides that a PSRO's determination shall constitute a conclusive determination for purposes of payment under medicaid only if the PSRO has entered into a memorandum of understanding (approved by the Secretary) with the appropriate State medicaid agency. The purpose of this memorandum is to delineate the relationship between the PSRO and the State agency. The requirement for a memorandum of understanding may be waived only if the State indicates that it does not wish to enter into such an understanding or if the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the PSRO involved.

A State medicaid agency may request a PSRO to include in its memorandum of understanding a specification of review goals and methods (in addition to those required in the PSRO's formal review plan) for the performance of its required functions. If the State medicaid agency and the PSRO are unable to agree on the inclusion of such items, the Secretary would review the requested specification and require that it be included in the memorandum if he determines that the review goals and methods are consistent with titles XI and XIX of the act and do not impair the effectiveness and uniformity of the PSRO's review of health care services under medicare and medicaid. For example, a State might request that a PSRO emphasize the prevention of unnecessary Friday admissions of medicaid patients for elective procedures not scheduled to be performed until Monday. Your committee notes that the PSRO's application of norms, criteria, and standards would not be affected by this provision; standards for quality, appropriateness and necessity of services would continue to be the same for both programs. If the PSRO found review of weekend admissions was appropriate, it would generally be applied to all patients whose care was reviewed by the PSRO.

Your committee intends that the Secretary shall not deny a State agency request solely because the PSRO has not been utilizing such a requested method or goal for the medicare program or because the PSRO cannot apply the method or goal to the medicare program due to differences in the patient populations. Rather, the Committee intends that where differences in the patient populations do not preclude uniform review by the PSRO, the Secretary's decision shall be based on his determination as to whether the PSRO can effectively apply such review methods or goals to the review of services provided under both the medicare and medicaid programs in order to ensure that the uniformity of PSRO review under the Social Security Act can be maintained.

The committee intends that any review specified by the State agency which the PSRO performs in accordance with its memorandum of

understanding with the agency and pursuant to its review authority until title XI would be fully federally funded. In addition, the bill provides regular Federal matching if a medicaid State agency contracts with a PSRO to undertake additional review responsibilities, provided the State agency formally requests it and the performance of such responsibilities is provided for in an approved medicaid plan amendment For example, the State agency may request the PSRO to approve so-called administrative days, such as an additional day of hospital stay which may be required because there is no immediately available skilled nursing facility bed.

The bill also provides Federal financial participation to State medicaid agencies for the costs of monitoring the performance of review activities by PSRO's under State monitoring plans which have been approved by the Secretary. It is expected that the Secretary will develop criteria for approval of such plans and that they will not be approved where the proposed monitoring activities duplicate the purposes of PSRO review. The State medicaid agency may include in its plans for monitoring a specification of the performance criteria for judging PSRO effectiveness. Your committee has not mandated inclusion of such specifications in the State's monitoring plan because it is believed that most States during the development and initial implementation of State monitoring of PSRO review will not have such performance criteria developed. However, at such time as the State agency intends to utilize performance criteria for judging PSRO review effectiveness, your Committee expects the agency to discuss the criteria with the PSRO and to amend the State's monitoring plan to include the agreed-upon criteria.

The bill authorizes the State agency to request suspension of the PSRO's authority to make conclusive determinations if in the course of its monitoring activities it develops reasonable documentation that the PSRO review determinations have caused an unreasonable and detrimental impact either on total State medicaid expenditures or on the quality of care. Within thirty days of receipt of the documentation the Secretary is required to suspend all or part of the PSRO's conclusive determination authority under medicaid. (For example, he may suspend their review of long-term care services, but not hospital services. He may also take similar action with respect to PSRO determinations under medicare if he determines such action is appropriate.) During the suspension period the Secretary is required to conduct a reevaluation of the PSRO's capability to perform review activities and to inform the appropriate agencies, organizations, and congressional committees of any documentation submitted and actions taken.

The bill requires the Secretary to establish procedures and mechanisms governing his relationship to State agencies in connection with their respective responsibilities concerning memoranda of understanding, monitoring, and reevaluations. The Secretary is required to periodically consult with representatives of State agencies and PSRO's. Further, the appropriate State medicaid agency is permitted to be represented on any project assessments conducted by the Secretary. Your committee intends that the procedures and mechanisms developed by the Secretary shall promote smooth working relationships between all parties involved and shall involve a minimum of disrup-

tion in the orderly implementation of the PSRO program. Your committee further intends that State monitoring activities will become less intensive over time (particularly with respect to PSRO's which are no longer in conditional status) and will focus on problem areas which have been detected in the performance of PSRO review.

Your committee is aware of the fact that as PSRO's begin to review services provided in institutional settings other than hospitals, different requirements may be appropriate. Accordingly, the bill prohibits delegated review in skilled nursing facilities since these facilities have generally had far less experience in conducting in-house review activities than hospitals. Further, PSRO review of care in intermediate care facilities and public institutions for the mentally retarded (services which are paid for only under the medicaid program) would only be undertaken where the Secretary determines that the State is not performing effective review of the quality and necessity of services provided in such facilities. If the Secretary does make such a finding, and the PSRO is required to carry out the review, the committee expects that the PSRO would not delegate review to the intermediate care facility, just as they are prohibited from such delegation to skilled nursing facilities.

Clarification of Sanctions Provision (Section 5(e))

Current law specifies those conditions under which the Secretary may, at the recommendation of a PSRO, withdraw a medical care provider's eligibility to participate in Social Security Act medical care programs where it is determined that it is not willing, or cannot, carry out its obligations to order and provide only necessary care of acceptable quality.

The bill makes clear that the provision in question applies to any health care practitioner, or any hospital or other health care facility, agency, or organization which is subject to PSRO review.

National Council (Section 5(f))

The bill provides for staggered terms for members of the National Professional Standards Review Council.

Present law provides that the 11 members of the Council shall be appointed for three-year terms and may be eligible for reappointment. Your committee's bill would amend this provision. The general term for Council members would continue to be three years, except that for members appointed in 1979, four shall be appointed for a two-year term and three for a one-year term. All members would continue to be eligible for reappointment.

National Council Report (Section 5(g))

Section 5(g) would delete the requirement in present law for an annual report on its activities by the National Professional Standards Review Council and would require instead the submission by the Secretary of a detailed annual report on the PSRO program.

Under the new reporting requirement included in your committee's bill, the Secretary would be required to submit substantially more information concerning the cost and operation of the PSRO program than has previously been required of the National Council. Accordingly, the bill would delete the requirement for the National Council report as duplicative and unnecessary.

Exchange of Data and Information With Other Agencies (Section 5(h))

Your committee's bill would expand and clarify the circumstances under which the provision of data or information by PSRO's would not violate the confidentiality requirement of law.

Under present law, any data or information acquired by a PSRO in the exercise of its duties must be held in confidence and may not be disclosed to any person except (1) to the extent that may be necessary to carry out the purpose of the PSRO provisions, or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care. Interim regulations issued by the Department on December 3, 1976, provide for the disclosure of two types of information acquired by the PSRO:

1. Data and information acquired by the PSRO: (a) which has been published; (b) which has not been identified by the source as confidential; and (c) whose disclosures are not otherwise prohibited by law.

2. Summary statistics aggregated from the Uniform Hospital Discharge Data Set (UHDDS) to the extent that it is not identifiable to an individual patient or health care practitioner.

Your committee's bill would expand and clarify those circumstances under which the provision of data or information would not violate the confidentiality provisions to include: (1) provision of data or information by the PSRO, on the basis of its finding as to evidence of fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities; such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO; and (2) provision of aggregate statistical data to agencies having responsibility for health planning and related activities under Federal or State law. The data and information furnished to the planning agencies would be provided in the format and manner prescribed by the Secretary or agreed upon by the agencies and the PSRO. Such data and information would be in the form of aggregate statistical data on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished and the demographic characteristics of the population whose services are subject to review by the PSRO. However, the data would not identify any individual.

Data and information made available to Federal or State agencies recognized by the Secretary as having responsibility for identifying and investigating fraud and abuse may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding. Violation of this prohibition would result in application of the penalty specified in existing law.

Your committee has included this provision to facilitate the exchange of data and information with other agencies while at the same time assuring that the confidentiality of patient records will not be violated. The committee has received information that PSRO's which have identified suspected cases or widespread patterns of fraud and abuse have been unable to make the information available to enforcement agencies. Your committee also notes that the provision of aggre-

gate statistical data to Federal and State planning agencies will enable those bodies to develop a more accurate picture of medical care patterns in their areas, facilitate planning for future resource needs, and prevent unnecessary duplicative data gathering activities.

Your committee's bill also includes a provision to protect patient records from subpena or discovery proceedings in a civil suit. This provision, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

Legal Expenses (Section 5(i))

Your committee's bill provides for payment of legal fees in connection with the defense of suits brought against a PSRO related to the performance of its functions. The bill would authorize the Secretary to assume responsibility for legal fees incurred in connection with the defense of any suit, action, or proceeding brought against the PSRO or any of its members or employees related to the performance of its functions. Your committee notes that while all PSRO's currently have liability insurance which covers such attorneys' fees, this provision would serve as an additional guarantee in the event such insurance is subsequently withdrawn.

Payment of PSRO Expenses (Section 5(j))

Your committee's bill would clarify the intent of present law that payment for PSRO expenses is to be made from Federal funds.

Under present law, expenses incurred by PSRO's are payable from medicare trust funds and from funds appropriated to carry out the other health care provisions of the Social Security Act. The bill would clarify that it is not intended that States or local governmental entities contribute toward these expenses, as they normally must do to receive Federal matching funds under title XIX.

Annual Reports (Section 5(k))

Current law does not require the preparation of a detailed report on the activities, cost, and impact of the PSRO program. Your committee believes that this information is necessary to determine the status of program operations, to evaluate the progress of program implementation, and to assess the program's effectiveness.

The bill therefore requires the Secretary to submit annual reports to the Congress by April 1 of each year beginning in 1978 on the administration, impact, and cost of the PSRO program during the preceding fiscal year. The reports must include program data on each PSRO; institutions and practitioners whose services are subject to review; services determined by PSRO's not to meet standards; penalties and sanctions; total costs under titles V, XI, XVIII, and XIX in the implementation of all required review procedures; changes attributable to PSRO activities; progress in adopting and implementing ambulatory review methodologies; results of program evaluation activities; extent to which PSRO's are performing reviews for other private or governmental programs; and legislative recommendations.

Report of the Secretary; Confidentiality of Medical Records (Section 5(l))

Your committee's bill requires the Secretary, after taking into account the recommendations of the Privacy Protection Study Commission, to submit recommendations to the Congress pertaining to the

privacy of patients' medical records, the circumstances under which records may be appropriately examined and the safeguards that need to be established with respect to such examinations and the disclosure of records.

Your committee is concerned that sufficient safeguards may not currently exist to protect the privacy of patients' medical records. Existing policies with respect to access to medical records by agents of the Federal Government, as well as others, may provide opportunities for unnecessary invasions of individual rights of privacy. The Committee is convinced that the issue of confidentiality requires thorough reexamination. Attention needs to be given as well to the possible use of more stringent limitations on Federal access to records, though such limitations must be designed in such a way as not to impede the ability of the government to carry out necessary epidemiological and other research activities and to perform vital public health functions. It is the Committee's understanding that the Privacy Protection Study Commission has been conducting an in-depth study of these issues and will be submitting its final report in June 1977.

Your committee's bill therefore requires the Secretary to submit to the appropriate congressional committees, within three months of the issuance of the final report of the Commission, a report and legislative recommendations for appropriate procedures to maintain the confidentiality of all individually identifiable medical records, and to provide for appropriate safeguards against unwarranted inspection or disclosure of such records.

While recognizing the need for a thorough reexamination of the entire issue of the confidentiality of medical records, your committee has also included in the bill provisions affecting access to and the inspection of medical records by PSRO's and employees or agents of the Federal government. Under the bill, PSRO's and employees or agents of the Federal government may not inspect, acquire or require the disclosure of individually identifiable medical records unless the patient has executed a signed and dated consent statement authorizing inspection or disclosure for a specific time period, identifying the records to be inspected or disclosed, and specifying the purposes for which (and the agencies to which) such records may be inspected or disclosed.

Under the bill, the requirement of patient authorization would not apply, however, to the inspection, acquisition, or disclosure of an individually identifiable medical record relating to medical care which is paid for (in whole or in part) by the medicare or medicaid programs where such inspection, acquisition or disclosure (1) is by a PSRO for the purpose of reviewing services furnished to medicare or medicaid beneficiaries, or (2) is for the purpose of auditing for, investigating or prosecuting fraud or abuse in the provision of, or payment for, such medical care.

Your committee is cognizant of the fact that the Privacy Commission has recommended that legislative action on the issue of confidentiality of medical records is needed with respect to all types of medical records wherever located and by whomever maintained (including both private and public sites and holders of records) and with respect to the great variety of public and private purposes for which

such records may be sought or needed. Thus, by including in your committee's bill the requirement for the Secretary to submit comprehensive legislative recommendations to the committee following the publication of the Privacy Commission's report, your committee is prepared to fully reassess the confidentiality issue at such time as the Secretary provides the legislative recommendations required by the bill.

Medical Officers (Section 5(m))

Your committee's bill would include medical officers in American Samoa, the Northern Mariana Islands and the Trust Territory of the Pacific Islands in the PSRO program. The committee notes that in these areas medical officers rather than doctors of medicine provide medical care. The bill would therefore permit medical officers licensed to practice medicine in these localities to participate in the PSRO program. These individuals may not, however, serve on the National Council or make any final determinations with respect to medical necessity or appropriateness of care provided by a duly licensed doctor of medicine or osteopathy.

Payment for Review of Part B Services Provided by Hospitals (Section 5(n))

Public Law 94–182, enacted on December 31, 1975, included an amendment to the medicare program which was designed to equalize reimbursement for PSRO hospital review activities whether such review was carried out by a hospital under delegation from a PSRO or by the PSRO itself. Previously, only delegated review activities could be funded out of the medicare trust funds. Under the new law, PSRO expenses in carrying out nondelegated review for hospital services covered under medicare part A or medicaid or the maternal and child health program would also be reimbursed through this mechanism. The law did not, however, provide for similar funding for PSRO review of hospital services covered under medicare part B.

Accordingly, the bill corrects this oversight by providing that funding for delegated review activities for services provided by a hospital which are covered under medicare part B shall be made from the medicare trust funds.

Statewide Councils (Section 5(o))

Your committee's bill extends the protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of Statewide Professional Standards Review Councils.

Issuance of Subpenas by the Comptroller General (Section 6)

Your committee's bill would give the Comptroller General of the United States the power to sign and issue subpenas to gain information regarding health programs authorized under the Social Security Act.

Currently, the Comptroller General of GAO does not have the statutory authority, under the Social Security Act, to issue subpenas in connection with GAO investigations into health programs authorized by that Act. In a December 29, 1976, letter to the committee, which was in response to an inquiry concerning Social Security Act subpena power

for the General Accounting Office, the Acting Comptroller General stated that:

> From the overall perspective, we believe that the subpena power in question would be a useful tool. In all probability, the mere existence of such a power would be sufficient to preclude problems in most cases and, in our opinion, resort to its use would be relatively infrequent. We would thus favor the inclusion of subpena authority in the anticipated new legislation.

The bill would give the Comptroller General of GAO the power to sign and issue subpenas in order to gain information and facilitate review of medicaid, and the maternal and child health programs particularly with respect to investigations of fraudulent and abusive practices. In connection with GAO's statutory functions including investigations, examinations, and auditing, subpenas could be issued to gain access to pertinent books, records, documents, or other information.

Under resistance or refusal by an individual to obey a subpena, the bill would authorize the Comptroller General to request a court order requiring compliance.

In granting GAO the power to subpena books, records, and documents, the committee is aware that the personal medical records of beneficiaries and recipients could be subject to subpena. In the context of the bill personal medical records are defined to mean any information relating to an individual's medical or mental condition or treatment that is acquired by GAO in the course of its investigations into Social Security Act health programs, in a form that could identify the individual.

The committee strongly believes that confidentiality of such records must be protected and has, therefore, placed strict controls on the disclosure of such information by GAO personnel. The bill would prohibit the disclosure of personal medical records subpenaed by GAO to any person except those GAO employees whose official duties require seeing them. GAO personnel illegally disclosing such records would be subject to a $1,000 fine, six months imprisonment, or both: and if convicted, prosecution costs. In addition, the bill would exclude the copies of all personal medical records in GAO possession from subpena or discovery proceedings in a civil action. This exclusion, however, would not preclude the subpena or discovery of originals or copies of the same documents in the possession of others.

The bill would permit GAO disclosure of personal medical records only to Federal or State agencies authorized to investigate cases or patterns of fraud and abuse under Social Security Act health programs. Prior to such disclosure, however, the Comptroller General must determine that such records actually reveal evidence of fraud and abuse.

Suspension of Practitioners Convicted of Medicare- or Medicaid-Related Crimes (Section 7)

Your committee's bill requires the suspension of physicians or other individual practitioners from participation in medicare or medicaid if such practitioner has been convicted of a program-related criminal offense.

The committee has included this provision in response to the concern that some program violators have been permitted continued participation, often without interruption, in Federal health care programs. The committee feels that misuse of Federal and State funds is a very serious offense and that those convicted of crimes against the programs should not be permitted continued and uninterrupted receipt of Federal and State funds. The committee believes that this threat of suspension, together with the upgraded penalties authorized under the bill, will serve as a significant deterrent to fraudulent practices under medicare and medicaid.

Under current law, physicians or other individual practitioners who have been convicted of an offense related to their participation in medicare or medicaid are not automatically suspended from these programs and can continue to receive payment therefrom. The Secretary may suspend Federal payment to a person who has falsified information related to a request for payment. The Secretary may also suspend a person who bills the program for charges substantially in excess of the person's customary charges or who has furnished services found to be substantially in excess of an individual's needs, to be harmful, or to be of grossly inferior quality.

The bill requires the Secretary to suspend from participation under medicare, a physician or individual practitioner who he determines has been convicted of a criminal offense related to such individual's involvement in medicare or medicaid. To permit case-by-case determinations, the suspension would be for such period as the Secretary deems appropriate and no medicare payment could be made for any item or service furnished by such individual during this period. Individuals subject to suspension are those who are convicted on or after the date of enactment of the law or within such period prior to enactment as the Secretary may specify in regulation. Provision is made for appropriate notice to the individual and the public and hearing and judicial review of the Secretary's determination. In any case where the Secretary suspends a practitioner from participation in medicare he is required to promptly notify every State medicaid agency and the appropriate State or local licensing authority.

Whenever a State medicaid agency is notified by the Secretary that a practitioner has been suspended under medicare, it shall suspend such individual from participation in medicaid. This is intended to prevent practitioners from moving from one State to another in order to avoid the effect of the suspension. To conform the timing of suspensions, the medicaid suspension period shall not be less than the suspension period applicable to the individual under medicare. No medicaid program payments may be made for services provided by such individual during the suspension period.

In his notification to the licensing authority the Secretary shall request that investigations be made and sanctions be invoked, as deemed appropriate in accordance with the State's law and policy. The Secretary and Inspector General would be notified of whatever action, if any, is taken by these authorities.

The committee was concerned that imposition of this suspension, under certain unusual circumstances, could deny adequate access to medical care to persons eligible for services under medicare or medic-

aid. To ensure that this would not occur, the bill provides two remedies. First, the bill would authorize the Secretary to designate a community as a health manpower shortage area (as defined under title III of the Public Health Service Act) for purposes of placement of National Health Service Corps personnel, if he determines that imposition of a suspension would leave those residents of the area eligible under medicare or medicaid without adequate access to health services. Second, the bill permits the Secretary, on the request of a State, to waive a practitioner's suspension under the State's medicaid program. Your committee intends that such waivers be granted sparingly. It is expected that waivers will only be approved where imposition of the suspension would deny a community of needed medical service because of the shortage of practitioners in that area and no National Health Service Corps personnel have been assigned.

Disclosure by Providers of Owners and Certain Other Individuals Convicted of Certain Offenses (Section 8)

Your committee's bill requires all institutional providers of services participating in medicare, medicaid, or title XX State social service grant programs to disclose the names of owners and certain other individuals who have been previously convicted of fraud against any one of these programs.

Current disclosure of ownership provisions do not require institutional providers of services and other agencies and organizations certified to provide services under titles XVIII and XIX of the Social Security Act to disclose information about criminal records any of their owners and managerial employees may have. Similar information is also not required from institutional providers participating in title XX of the Social Security Act, a number of whom are also certified to provide services under medicare and medicaid. Existing procedures for determining this information are inadequate, time-consuming, and have permitted individuals previously convicted of such offenses to continue ownership or management in participating facilities or become owners or managers in other participating facilities without program administrators being aware of an individual's past activities which might have a bearing on a facility's future performance.

Lack of adequate disclosure of these individuals is an additional restraint on HEW's attempts to investigate and control program abuse. It has hampered and restricted Department efforts to limit the participation of those facilities and other organizations providing services under titles XVIII, XIX, or XX that are partially owned or controlled by persons convicted of criminal offenses against the programs.

Even when such individuals can be identified by the Department of HEW or State administering agencies, it is difficult under existing procedures to limit participation of facilites owned by these persons. Currently, no provisions exist to enable the Secretary of HEW or a State agency to refuse to enter into or to terminate provider agreements or contracts with institutional providers or other organizations owned by such individuals as long as existing conditions for participation under titles XVIII, XIX, or XX are met.

As a condition of participation, certification, or recertification under titles XVIII, XIX, or XX of the Social Security Act, the bill would require all institutional providers of services, or other agencies, institutions, or organizations to disclose to the Department of Health, Education, and Welfare or to the appropriate State agency the names of its owners, officers, directors, agents, or managing employees who have been convicted of a criminal offense against medicare, medicaid, or State social service grant programs. The bill specifies that when an application requesting such participation or certification contains the names of any such previously convicted individual, the Secretary of HEW or the State agency may refuse to enter into an agreement or contract with the institution to provide services under titles XVIII, XIX, or XX. In addition, the bill specifies that the HEW Inspector General must be informed of any such applications received and of any actions taken on them. The bill would also permit the Secretary or appropriate State agency to terminate existing provider agreements or contracts under titles XVIII, XIX, or XX, if the names of such individuals have not been disclosed, as required.

In applying the disclosure requirements to convicted persons who are officers, directors, agents, or managing employees of the institution, as well as to convicted persons with ownership interests, the committee feels that this parallel requirement is necessary in order to ensure that program administrators are aware of the renewed involvement of these persons in participating institutions.

The bill would specifically define the term "managerial employee" to mean a person who exercises operation or managerial control over the institution or one who directly or indirectly conducts the day-to-day operations of the institution including, but not limited to, an institution's general manager, business manager, administrator, and director. The bill would define the owner of an institution as any person who has a direct or indirect ownership or control interest of at least five percent in the institution.

Federal Access to Records (Section 9)

Under present law, State plans under medicaid are required to provide for agreements with every person or institution providing services whereby such persons or entities will keep complete records of services provided under the program and furnish the State agency, upon request, with information regarding any payments claimed under the program. Similar access to records by the Secretary is not required. The committee feels this could hamper Federal efforts to obtain information necessary to examine potential instances of fraudulent and abusive activities. Your committee bill therefore specifically permits the Secretary to have access to records of persons or institutions providing services under medicaid in the same manner presently provided to State medicaid agencies.

Claims Processing and Information Retrieval Systems for Medicaid Programs (Section 10)

Your committee's bill permits States to send explanation of benefits forms to a sample of medicaid recipients and still be entitled to increased Federal matching for operation of approved management information systems. No explanation of benefit forms would be required in the case of services which are confidential in nature.

Present law authorizes an increase in Federal matching to 75 percent toward the costs of operating an approved medicaid claims processing and information retrieval system if the system provides explanation of benefits information to all recipients. The committee has been informed that this strict requirement for explanation of benefit forms in every case has limited the growth of approved systems. In addition, questions have been raised about the cost effectiveness of this requirement because of the high volume of claims for services provided under medicaid.

The bill therefore modifies the current requirement by permitting the increased matching if the system provides explanation of benefits information to a sample group of recipients. The committee expects that the samples will be of sufficient size and sufficiently representative of the population served and the services rendered to enable the identification of any questionable or unusual patterns. It is the intention of the committee that all confidential services, and services integrally related to a confidential service, be deleted from the explanation of benefit forms in order to assure privacy for the medicaid patient. States will be expected to institute appropriate safeguards to accomplish this.

Your committee notes that this change in the medicaid statute does not constitute a new entitlement to higher Federal matching, but merely increases the workability of the existing provision.

Medicaid As Payor of Last Resort (Section 11)

Your committee's bill precludes Federal matching payments for expenditures under medicaid for services which a private insurer would have an obligation to pay except for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid.

Under current law, States or local agencies administering medical assistance plans are required to take all reasonable measures to ensure that third parties legally liable to pay for any medical care rendered to medicaid recipients meet their legal obligations. However, some private insurance policies contain a provision that limits the insurance companies' liability to the amount not covered by medicaid. In some cases, State insurance commissioners have not taken action to stop this practice. When it occurs, the medicaid program is forced to assume the costs despite the existing subrogation requirement.

The bill would provide an incentive to States to stop this practice by stopping all Federal matching payments for expenditures made under the plan for care or services provided to the extent the private insurer (as defined by the Secretary) would have been obligated to pay except for a provision of its contract which has the effect of limiting or excluding such obligation because the individual is receiving assistance under medicaid.

Study and Review of Medicare Claims Processing (Section 12)

Your committee's bill directs the Comptroller General to conduct a comprehensive study of the claims processing system under medicare for the purpose of determining what modifications should be made to achieve more efficient claims administration.

Under medicare part A, groups or associations of providers can nominate an organization to serve as a fiscal intermediary between the providers and the government. An individual member of an association or group of providers that has nominated one organization as intermediary may select some other organization if this is satisfactory to the organization and HEW, or alternatively it may elect to deal directly with the government. HEW may not enter into an agreement with an organization unless it finds that such agreement is consistent with efficient and effective administration. The Social Security Administration has selected 10 hospital-nominated organizations to serve as intermediaries. This includes the Blue Cross Association which carries out its claims administration activities through 73 statewide and local Blue Cross Plans. Under medicare part B, the Secretary contracts with carriers to perform claims processing activities. Carriers are selected to serve specified geographic areas. There are 47 carriers, including 32 Blue Shield plans. Both intermediaries and carriers are reimbursed on a cost basis for carrying out their activities.

The Committee believes that it is necessary to conduct a reexamination of the administrative framework of the medicare program in order to assess the need for possible modifications.

Your committee bill therefore directs the Comptroller General to conduct a comprehensive study and review of the administrative structure established for processing claims under medicare. The study is to determine whether and to what extent more efficient claims administration could be achieved by reducing the number of carriers and intermediaries, making a single organization responsible for processing claims under parts A and B in a particular geographic area, paying for claims processing on the basis of a prospective fixed price, providing other types of incentive payments for efficiency, or by other modifications in existing structure and procedures. The Comptroller General would be required to submit a report containing his findings and recommendations to the Congress by July 1, 1979.

Abolition of Program Review Teams Under Medicare (*Section 13*)

Your committee's bill repeals the provisions in current law relating to program review teams.

The Social Security Amendments of 1972 included a provision authorizing the Secretary to suspend or terminate medicare payments to a supplier of services found to have abused the program. In the case of such a suspension or termination, Federal participation was also to be withheld for medicaid payments made in behalf of such supplier. This provision was included to permit HEW to bar future payments to suppliers who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services.

To assist him in making determinations under this section, the Secretary was required to establish program review teams in each State. These professionally-based bodies were to advise the Secretary concerning such matters as whether excessive, harmful, or grossly inferior care is being rendered to patients. Your committee believes that the functions of program review teams relating to the review of the quality and appropriateness of services are essentially duplicative of the functions required to be performed by PSRO's.

The bill therefore deletes the requirements in current law pertaining to the establishment and responsibilities of program review teams. The committee expects that the appropriate PSRO will instead be available to advise the Secretary in cases that require the application of professional medical judgment.

Amendments Relating to Fiscal Intermediaries (Section 14)

Your committee's bill authorizes the Secretary, after taking into account the provider's nomination and after applying the appropriate standards and criteria required under this section, to assign and reassign providers to available intermediaries. He is also authorized, after applying the required standards and criteria, to designate regional intermediaries or a national intermediary with respect to a class of providers. The bill requires the Secretary to develop standards, criteria, and procedures for evaluating the adequacy of intermediary performance, and the efficiency and effectiveness of program administration, and to apply such standards and criteria in making determinations as to the participation and role of intermediaries in the program. Intermediaries are required to provide access by the Secretary to necessary data and information.

Under part A of medicare, groups or associations of providers of services, i.e., hospitals, extended care facilities, and home health agencies, can nominate an organization to act as a fiscal intermediary between the providers and the Secretary. An individual member of an association or group of providers which has nominated one organization as intermediary may select some other organization as its intermediary if this is satisfactory to the organization and the Secretary, or alternatively, it may elect to deal directly with the Secretary. The Secretary may enter into an agreement with a nominated organization only if he finds that this would be consistent with efficient and effective administration and that the organization is able and willing to assist providers in the application of safeguards against unnecessary utilization of services.

Your committee notes that the provision giving providers considerable latitude in their selection of intermediaries was included in the original medicare law in order to facilitate a smooth transition to the new health insurance program. While recognizing the contribution intermediaries generally have made toward the successful implementation of the medicare program, your committee believes that some potential for conflicts of interest exists under a system where intermediaries are responsible for fulfilling title XVIII requirements on the one hand, while on the other, their continued role as intermediaries is often contingent upon the providers' satisfaction with them. While the committee does not mean to imply that such conflicts are pervasive, or that many intermediaries have been lax in performing their functions, your committee has received some evidence, particularly in the case of home health agencies, of ineffective intermediary performance.

Your committee is also aware that the results of some of the current measures now used to evaluate intermediary performance are not always reliable indicators of performance. For example, for the quarterly reporting period July-September 1976, the adjusted cost per claim ranged from $2.73 to $7.21 with a weighted national average

of $4.50. For the same time period, the adjusted number of claims per 100 man hours ranged from 155 to 399 with a weighted national average of 242. The committee recognizes that existing performance measures have not been sufficiently refined to determine the extent to which the variances reflect actual differences in costs rather than differences in accounting and reporting practices. The committee further notes that even where cost differences occur, lower costs do not necessarily imply a more efficient and effective operation. Other factors, such as the types of claims processed, are relevant to the assessment of performance. The committee, therefore, believes that it is imperative that more precise and uniform standards and criteria for evaluating the performance of intermediaries in the administration of the program need to be developed and that such objective standards and criteria need to be applied by the Secretary in making determinations with respect to the renewal or termination of agreements, as well as the assignment of providers, and the designation of regional or national intermediaries.

The bill therefore includes provisions designed to permit improvements in the administration of the hospital insurance program. In the interest of efficient and economical program administration, the bill authorizes the Secretary to assign and reassign providers to available intermediaries. While the bill retains the present provision of law allowing a provider to designate a preference through the nomination process, the Secretary would not be bound by a provider's choice. His decision must be based on a finding made, after applying the required standards and criteria with respect to the intermediary chosen by the provider, that in this particular instance reassigning a provider to another intermediary will result in more effective and efficient administration of the program. Your committee's bill requires that if the Secretary makes a determination which is not in accord with the provider's preference, the provider and his chosen intermediary be given a full explanation of the reasons for the Secretary's determination, and the intermediary be provided with an opportunity for a hearing.

The bill also authorizes the Secretary to designate regional intermediaries or a national intermediary to perform the required functions with respect to a class of providers (such as home health agencies) if he determines, after applying the appropriate standards and criteria to all affected intermediaries, that such designation would result in more effective and efficient administration. Such designations may not be made until the affected providers and intermediaries are provided with a full explanation of the reasons for his determination and the intermediaries are granted an opportunity for a hearing.

Your committee's bill further provides that determinations by the Secretary with respect to the assignment or reassignment of a provider to an intermediary other than the one nominated by the provider and the designation of a regional or national intermediary would be subject to judicial review in accordance with the appropriate provisions of the Administrative Procedures Act. It is your committee's intent to assure that in making such determinations the Secretary complies with the requirements of due process applicable to such administrative decisions. Moreover, your committee expects that such determinations will not be implemented, in the event an intermediary contests the

Secretary's determination, until such time as the affected intermediary has exhausted the appeal rights available to it under this bill.

The bill requires the Secretary to develop standards, criteria, and procedures to enable him to evaluate intermediaries' performance of the claims processing and other related functions required to be performed by them and to permit him to make objective determinations with respect to the efficiency and effectiveness of program administration. The Secretary is required to develop such standards, criteria and procedures by October 1, 1978, and apply them in making determinations relating to the renewal or termination of agreements with intermediaries, the assignment or reassignment of providers and the designation of regional or national intermediaries beginning on that date.

The bill further requires that agreements with intermediaries provide for access by the Secretary to all data, information and claims processing operations as he may find necessary to enable him to perform his required functions.

Disclosure by Providers of the Hiring of Certain Former Employees of Fiscal Intermediaries (Section 15)

Your committee's bill would require a provider of services under the medicare program to notify the Secretary promptly of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing or similar capacity by a fiscal intermediary or carrier who had served that provider.

The committee was distressed to learn that in certain cases providers have specifically recruited and employed personnel of the fiscal intermediary serving it, apparently in order to assist the provider in justifying questionable accounting and cost reporting procedures. The committee strongly opposes this type of hiring practice which it sees as potentially subverting the integrity of the intermediary-provider relationship, including the integrity of the auditing process. The committee expects the Department of HEW to utilize the information gained under the notification required under the bill to discourage such practices, especially when such information suggests possible conflict of interest situations.

Providers who hire employees of fiscal intermediaries, particularly accountants and auditors who have been involved in auditing that provider, should be on notice that this committee will be following such practices closely.

Payment for Durable Medical Equipment (Section 16)

Your Committee's bill would modify the present methods for reimbursing medicare beneficiaries for expenses incurred in obtaining durable medical equipment. The intent of this modification is to reduce program expenditures and assure greater protection for beneficiaries against the need to pay excessive rental fees.

Present law provides for reimbursement under part B of medicare for expenses incurred in the rental or purchase of durable medical equipment used in the patients' home. The beneficiary has the option to rent or purchase such equipment. In the case of purchase, reimbursement is generally made in monthly installments equivalent to amounts that would have been paid had the equipment been rented.

Reimbursement may be made on a lump-sum basis for purchased equipment that is relatively inexpensive, i.e., items for which the reasonable charge is $50 or less.

Where a beneficiary elects to rent equipment, medicare will continue to reimburse him for 80 percent of his rental expenses as long as his medical need for the equipment continues. A study conducted by GAO showed that rental payments under the program for durable medical equipment required over an extended period of time frequently exceeded, by a substantial amount, the reasonable purchase price of the equipment. Moreover, beneficiaries were also overpaying for equipment since they are liable for the 20 percent coinsurance amount.

The Social Security Amendments of 1972 added provisions to the law to help avoid unreasonable expenses to the program and to beneficiaries resulting from prolonged rentals of equipment. These provisions authorized the Secretary to experiment with alternative reimbursement mechanisms, including the use of lease-purchase arrangements and lump-sum payments for purchased equipment where it could be determined in advance that the use of the equipment would be medically necessary for an extended period of time. Although the Department has not conducted the extensive experimentation contemplated by the legislation, sufficient evidence is available to indicate that changes in the reimbursement methods are needed to deal with the long-standing problems arising under the durable medical equipment provision of law.

To remedy these problems, your Committee's bill makes several changes in the methods used in reimbursing beneficiaries and suppliers for durable medical equipment. First, the bill requires the Secretary to determine, on the basis of medical evidence, whether the expected duration of medical need for the equipment warrants the presumption that purchase would be less costly or more practical than rental, and would not impose financial hardship on the beneficiary. Where such a presumption can be made, the Secretary would require purchase of the equipment and would provide reimbursement on the basis of a lump-sum payment or on the basis of a lease-purchase arrangement. Since lease-purchase would generally be the preferred mode of payment, and would ordinarily provide the greatest degree of cost-effectiveness for the program and the beneficiary alike, the bill specifically directs the Secretary to take steps to encourage suppliers, through whatever administrative arrangements he finds feasible and economical, to make equipment available to beneficiaries on a lease-purchase basis.

Secondly, the bill retains the provision in existing law which authorizes the Secretary to waive the 20 percent coinsurance requirement with respect to the purchase of used durable medical equipment whenever the purchase price is at least 25 percent less than the reasonable charge for comparable new equipment.

Funding of State Medicaid Fraud Control Units (Section 17)

Your committee's bill authorizes 90 percent Federal matching payments for fiscal years 1978–1980, for the establishment and operation of State medicaid fraud control units.

Your committee is concerned that sufficient efforts have not been made to date to identify and prosecute cases of medicaid fraud. In the absence of effective investigative units, individuals engaging in fraudulent practices are able to continue their activities virtually unchecked. Sections of the bill provide for criminal sanctions and suspension actions for those convicted of medicaid fraud. However, strengthened penalties must be coupled with strengthened investigatory powers in order to assure that those engaging in criminal activities are identified and prosecuted. Further, the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to similar practices by other providers and practitioners.

During the hearings held on this legislation, testimony was presented showing that where a separate investigative entity has been established, the rate of prosecutions and convictions has been substantially increased. For example, there was testimony that in the period from 1970 to January 1975, there was not a single prosecution in New York State for medicaid fraud arising out of the operation of a nursing home. In January 1975, a special office was established to examine the rapidly growing scandal in the nursing home industry. As a result of its investigations, grand juries have indicted more than 90 individuals mostly for medicaid fraud. To date, there have been 27 convictions and the office has forced payment of more than four million dollars in criminal restitution—an amount several hundred thousand dollars in excess of the office's first year budget.

Your committee has learned that a number of States are interested in establishing or strengthening existing medicaid fraud control units. However, in view of the fiscal constraints being experienced by many of the States, the current 50 percent administrative matching rate has not served as a sufficient incentive to the establishment or expansion of such units. Your committee believes that a short-term increase in the Federal matching rate of 90 percent will enable States to establish effective investigative entities and expand existing efforts. After these units have been operational for a few years, their recoveries from prosecutions should begin to equal or exceed the cost of operation. Therefore, under the bill, the increased matching rate would only be in effect for three years.

The bill, therefore, provides for 90 percent Federal matching for fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units meeting specified requirements, subject to a quarterly limitation of the higher of $125,000 or one-quarter of one percent of total medicaid expenditures in such State in the previous quarter.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be a unit of the office of the State Attorney General or of another department of State government which has statewide prosecutorial authority, and such unit must be separate and distinct from the State medicaid agency. The entity is required to conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities

of medicaid providers. Such unit is not however required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. The fraud control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. In order to promote effective and efficient conduct of the entity's activities, it must be organized in a manner to achieve these objectives and it must employ auditors, attorneys, and investigators and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. To facilitate implementation of this section, the Secretary is required to issue regulations within 90 days of enactment.

The committee wishes to emphasize the need for the employment of highly skilled auditors, attorneys, and investigators specially trained in the area of medicaid fraud. The committee has received substantial evidence of the complex schemes employed by those engaging in fraudulent activities and notes that the only way such practices can be effectively addressed by utilizing persons specially skilled in uncovering these activities.

The committee intends that the increased matching rate authorized under this section be made available to existing State fraud control units providing they meet (or appropriately modify their operation so as to meet) the specified requirements.

Report on Home Health and Other In-Home Services (Section 18)

Your committee's bill would require the Secretary of Health, Education, and Welfare to report to Congress on home health and other in-home services authorized under titles XVIII, XIX, and XX of the Social Security Act.

The committee is concerned that, with respect to home health and in-home services authorized to be provided under medicare, medicaid, and title XX social service programs, more effective methods need to be developed to assure the quality of services provided and efficiency in administration of the programs, and more effective efforts to curb fraud and abuse. While it is understood that there are, by necessity, differences among these programs in entitlement to the services and the types of services covered, it is the feeling of the committee that any efforts to develop methods of quality assurance and administrative efficiency should, where possible and practical, provide for coordination between the programs, particularly with respect to requirements for providers of services and reimbursement methods.

The Secretary is, therefore, directed to submit within one year a report to the appropriate committees in Congress analyzing all aspects of the delivery of home health and in-home services authorized under these titles. Further, since the goal is to prescribe specific standards in the programs to assure high quality home health services and the protection of the health and safety of recipients of such services, the Secretary is required to report on regulatory changes needed and to

recommend appropriate statutory changes with respect to quality assurance and administrative efficiency. It is the feeling of the committee that this study should be conducted by the Secretary of Health, Education, and Welfare in view of the extensive information gathered by the Department during recent regional hearings on home health care and the subsequent activity of the Department in analyzing this information. The Secretary is to include in this report an analysis of the impact of his recommendations on the demand for and cost of services authorized under the programs and the method of financing any recommended increase in the provision of such services.

Uniform Reporting Systems For Health Services Facilities and Organizations (Section 19)

Your committee's bill would require the Secretary to establish for each of the different types of health services facilities and organizations a uniform system for the reporting of such items as cost of operation, volume of services, rates, capital assets and bill data. This reporting system would be mandated for use by medicare and medicaid providers and such use would be phased in by type of provider.

A persistent problem under the medicare and medicaid programs as currently structured is the presence of variations in the information contained in medicare and medicaid cost reports. Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the Subcommittee believes it is necessary to correct the deficiencies in the present reporting system under these programs. Your committee believes that this problem can be resolved by requiring the implementation of a uniform reporting system for all operational and capital costs of health care organizations.

Accordingly, the bill requires the Secretary to establish for each type of health service facility or organization a uniform system for the reporting of the following types of information:

(1) The aggregate cost of operation and the aggregate volume of services;

(2) The costs and volume of services for various functional accounts and subaccounts;

(3) Rates, by category of patient and class of purchaser;

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) Discharge and bill data.

It is your committee's intent that the uniform reporting system for each type of health service facility or organization provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type. The Secretary would be required to develop and establish uniform reporting systems, after consultation with interested parties, for hospitals, skilled nursing facilities and intermediate care facilities within a year following enactment of this legislation, and for other types of health service facilities and organizations (such as home health agencies) within two years of enactment.

Under the bill, the Secretary would require all medicare and medicaid providers of services to submit reports to the Secretary of the aforementioned cost-related information in accordance with the uniform reporting system. For hospitals, skilled nursing facilities, and intermediate care facilities, these uniform reports would be required beginning with their first fiscal year that begins more than six months after the reporting system has been promulgated by the Secretary. For all other types of health service facilities or organizations, the reporting requirement will only be implemented at such time (after such systems are promulgated for these institutions) as the Secretary deems to be most productive. After establishing the uniform systems of reporting, the bill requires the Secretary to monitor their operation, assist with support demonstrations and evaluations of the effectiveness and cost of the operation of such systems, encourage State adoption of such systems and periodically revise the systems to improve their effectiveness and diminish their cost.

Under the bill, the Secretary would be required to provide such information obtained through use of the uniform reporting system as may be necessary to assist health systems agencies and State health planning and development agencies in carrying out such agencies' functions.

Although proposals have been made to require uniform accounting as well as uniform reporting, the bill does not mandate a uniform accounting system. Your committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. Your committee is inclined to believe at this time that the uniform reporting system, with specific documentation for the reported costs as part of the organization's accounting system, is sufficient. Recognizing that further study of this complex issue may be warranted, the committee believes that it would be more appropriate to undertake such study in the context of deliberations on proposed cost containment legislation, rather than the anti-fraud and abuse legislation.

IV. Cost of Carrying Out the Bill and Effect on the Revenues

In compliance with subdivision (C) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the statement relative to the estimated costs of carrying out the bill provided to your Committee by the Director of the Congressional Budget Office follows:

Congressional Budget Office,
U.S. Congress,
Washington, D.C., June 3, 1977.

Hon. Al Ullman,
Chairman, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has reviewed H.R. 3, the Medicare-Medicaid Fraud and Abuse Amendments, with regard to its potential cost impact.

The provisions in H.R. 3 are intended to clarify and extend current statute in order to facilitate both state and federal efforts to monitor

and control possible fraud and abuse in the Medicare and Medicaid programs. This is accomplished in the bill through the expansion both of legislative powers and sanctions and of the collection and coordination of relevant information, as well as through the provision of increased funding to the states to support such activities. Lastly, as a means of further reducing costs, the bill permits the Secretary of HEW to require that necessary durable medical equipment be purchased rather than rented under Medicare if it is determined that purchase would be a less costly alternative.

Thus, many of the provisions in this Bill represent possible added costs or savings (or both) to the programs. Some sections, for example, although requiring additional expenditures, are intended to actually reduce costs, thus representing no net outlay effect. However, limitations of available and relevant data, uncertainties of the actual extent and effectiveness of the future implementation of the provisions, and the unknown magnitude of the fraud and abuse presently extant in the programs make it impracticable for CBO to project the actual cost impact of this measure at this time.

Our review of the bill and the limited information available leads us to conclude that costs and savings would essentially offset each other during the first couple of years of implementation with some savings accrued subsequently. This assessment is based upon the fact that the early years would involve both the necessary start-up costs and the time to bring the various activities up to a level where their full cost savings impact would be seen.

If we can be of further assistance to you in this matter, please feel free to contact me.

Sincerely,

ROBERT A. LEVINE,
(For Alice M. Rivlin, Director).

In compliance with clause 7 of rule XIII of the Rules of the House of Representatives, the following statement is made. Your committee concurs in the estimate furnished by the Director of the Congressional Budget Office relative to the cost impact of H.R. 3 as amended.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE HOUSE RULES

VOTE OF THE COMMITTEE

In compliance with subdivision (B) of clause 2(l)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the committee on the motion to report the bill, as amended. The bill, H.R. 3, as amended, was ordered favorably reported by a roll call vote of 37 in favor and 0 opposed.

OVERSIGHT FINDINGS

In compliance with subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the following statement is made relative to oversight findings by your committee.

In recent years, your committee's Subcommittees on Health and Oversight have found in their review of the medicare program disturbing patterns of fraudulent and abusive activities. These Subcom-

mittees have worked closely with both the Senate Committee on Aging and the Permanent Investigations Subcommittee of the Senate Government Affairs Committee as well as the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce in uncovering practices in both the medicare and medicaid programs which not only siphon off valuable program dollars but deprive the elderly and the poor of access to quality health care—access that was, and continues to be, the motivating purpose of these programs. Many of the problems that have been disclosed in the hearings, reports, and staff investigations of these committees and subcommittees are addressed in your committee's legislation. Information pertaining to other problems, which may be addressed more productively through administrative action, has been forwarded to the appropriate Federal agencies for further review.

NEW BUDGETARY AUTHORITY AND TAX EXPENDITURES

With respect to subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in present law by this bill involve no new budgetary authority or new or increased tax expenditures.

OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, your committee advises that no oversight findings or recommendations have been submitted to your committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

INFLATIONARY IMPACT

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, your committee states that the changes made in existing law by this bill would not have an inflationary impact on prices and costs in the operation of the national economy. It is your committee's intention that the improvement in the administration and operation of the medicare and medicaid programs sought in this bill will in fact slow the inflationary trend that has beset these programs in recent years.

VI. Section-by-Section Analysis

SECTION 2. PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS OF CLAIMS FOR SERVICES; CLAIMS PAYMENT PROCEDURES FOR MEDICAID PROGRAM

Section 2(a)(1) amends section 1842(b)(5) of the Social Security Act to add a new provision to that section which would strengthen and clarify the existing prohibition against assignment by physicians and others of payments for claims for services provided under the medicare program. The new provision specifies that payments made directly to a physician or other person providing a service, pursuant to an assignment agreement under section 1842(b)(3), cannot be made

to anyone else either through reassignment or under a power of attorney (except to an employer or facility as described under section 1842 (b)(5) (A) and (B)). The new provision also specifies that the prohibition contained in section 1845(b)(5) would not prevent payments made directly to the physician or other person providing the service from being assigned or reassigned, if such an assignment or reassignment is made to a government agency or entity or is established by or pursuant to the order of a court of competent jurisdiction. In addition, the prohibition contained in section 1842(b)(5) would not preclude an agent of the physician or other person providing the service from receiving payments under an assignment or reassignment if (but only if) the agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due the physician or other person under the medicare program, is unrelated (directly or indirectly) to the amount of the payments or the billings, and is not dependent upon the actual collection of any payment.

Section 2(a)(2) amends section 1815 of the Social Security Act to add a new section 1815(c). New section 1815(c) provides that payments due a provider of services under the medicare program could not be made to any other person under an assignment or a power of attorney. The new section further provides that the prohibition set forth under this section would not prevent an assignment of payments by the provider of service if the assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction. Further, an agent of the provider of services would not be precluded from receiving a payment under an assignment by the provider if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due the provider under medicare is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

Section 2(a)(3) amends section 1902(a)(32) of the Social Security Act by deleting it and inserting a new section 1902(a)(32) which provides that no payment under a State plan for medical assistance for any care or service provided to an individual could be made to anyone other than the individual or the person or institution providing the care or service, under an assignment or power of attorney or otherwise. Exceptions to this prohibition would be made in the case of physicians, dentists, or other individual practitioners who are required as a condition of their employment to turn over fees for care or service to their employers, or if there is a contractual arrangement between the individual practitioner and a facility where the care was provided under which the facility submits the bill for the care or service. New section 1902(a)(32) further provides that the prohibition set forth in this section would not prevent an assignment of payments from the person or institution providing the care or service involved if the assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction. In addition, an agent of the person or institution is not precluded from receiving any payment under assignment if (but only if) such agent does so pursuant to an agency agreement under which the compensation paid to the agent for his services for or in connection

with the billing or collection of payments due the person or institution under the State plan for medical assistance is unrelated (directly or indirectly) to the amount of the payments or the billings therefor, and is not dependent upon the actual collection of any such payments.

Section 2(a)(4) specifies that the amendments made under section 2(a) apply only to payments made for care and services furnished on or after the date of enactment of this legislation.

Section 2(b)(1) amends section 1902(a) by adding a new section 1902(a)(37) to ensure the proper and efficient payment of claims and management under the medicaid program. New section 1902(a)(37) requires State plans for medical assistance to provide for claims payment procedures that would: (A) insure that 90 percent of all claims for payment made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities will be paid within 30 days of the date such claims are received and that 99 percent of such claims will be paid within 60 days of the date they are received, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed.

Section 2(b)(1) further amends section 1902(a) to permit the Secretary of HEW to waive the requirement which provides time limits for claims payment, if he finds that the State has exercised good faith in trying to meet such requirements.

Section 2(b)(2) amends section 1903(a) by redesignating section 1903(a)(6) as 1903(a)(7) and inserting a new section 1903(a)(6). New section 1903(a)(6) would require the Secretary of HEW to pay each State with an approved State plan for medical assistance an amount equal to 90 percent of the sums spent during a quarter that are used to arrange and provide for programs of educational and technical assistance for health care practitioners which are likely (according to the Secretary's determinations) to expedite the filing and payment of claims for services provided under the State's plan. Assistance may be provided through outreach offices, the media, telephone hotlines, or such other means as the Secretary determines appropriate. Practitioners furnishing services under the medicaid program through individual or group practices or through shared health facilities are eligible for the assistance provided under new section 1903(a)(6).

Section 2(b)(2) further amends section 1903 by adding a new section 1903(l). New section 1903(l) provides that no payments may be made under new section 1903(a)(6) for any quarter ending after September 30, 1980. In addition, new section 1903(l) specifies that if payments to States under new section 1903(a)(6) for any calendar quarter exceed an aggregate of $1.25 million, then the amount of each State's payment would be reduced proportionately to bring the aggregate due the States down to $1.25 million.

Section 2(b)(3) sets forth the effective dates for the amendments made under sections (2)(b)(1) and (2). It specifies that the amendments relating to claims processing procedures made under section 2(b)(1) apply to calendar quarters beginning on and after January 1,

1978. The amendments relating to programs for educational and technical assistance under section 2(b)(2) apply to expenditures made in calendar quarters beginning on and after January 1, 1978.

SECTION 3. DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

Section 3(a)(1) amends part A of title XI of the Social Security Act by adding new section 1124, entitled "Disclosure of Ownership and Related Information." New section 1124(a)(1) directs the Secretary of HEW, by regulation or by contract provision, to require each disclosing entity (as defined in new section 1124(a)(2)) to supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in new section 1124(a)(3) in the entity. Disclosure of ownership or control interests would be required (a) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, and XIX, or (b) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under title V, XVIII, and XIX.

New section 1124(a)(2) would define the term "disclosing entity" to mean an entity which is:

(a) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, or a renal disease facility;

(b) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX; or

(c) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (1) an agreement under section 1816, (2) a contract under section 1842, or (3) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX.

New section 1124(a)(3) defines the term "person with an ownership or control interest" with respect to a disclosing entity as a person who:

(a) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity, or is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or

(b) is an officer or director of the entity, if the entity is organized as a corporation; or

(c) is a partner in the entity, if the entity is organized as a partnership.

New section 1124(b) would require a disclosing entity (to the extent determined feasible under the Secretary of HEW's regulations) to include in the information to be supplied about a person's ownership or control interests under new section 1124(a)(1), the name of any other disclosing entity in which that person has ownership or control interests.

New section 1124(c) would require a provider of services (as defined in section 1861(u), other than a fund) to also include in the information to be supplied under new section 1124(a)(1) full and complete information about the identity of each person with an ownership or control interest in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest.

Section 3(a)(2) deletes existing section 1861(j)(11) of the Social Security Act and replaces it with a new section 1861(j)(11) which requires a skilled nursing facility participating in medicare or medicaid to comply with the disclosure requirements of new section 1124.

Section 3(b) amends section 1866(b)(2) of the Social Security Act by adding a new provision to clause (C) which permits the Secretary of HEW to terminate an agreement with a provider of service who fails to comply with specific requests for (a) full and complete information about the ownership of a subcontractor (as defined in the Secretary's regulations) with whom the provider has had business transactions totalling more than $25,000 during the previous twelve months, and (b) full and complete information on any significant business transactions (as defined in the Secretary's regulations) occurring during the five-year period prior to the date of the request, between the provider and any wholly-owned supplier, or between the provider and any subcontractor.

Section 3(c)(1) amends section 1902(a) of the Social Security Act (as already amended by section 2(b)(1)) to delete existing section 1902(a)(35) and replace it with a new section 1902(a)(35). New section 1902(a)(35) requires intermediate care facilities receiving payments under State plans for medical assistance to comply with the requirements of new section 1124. In addition, section 3(c)(1) amends section 1902(a) by adding a new section 1902(a)(38). New section 1902(a)(38) would require an entity (other than an individual practitioner or a group of individual practitioners) that furnishes or arranges to furnish items or services under a State plan for medical assistance to supply upon specific request by the Secretary of HEW or the State agency administering the State plan (within such time as specified in regulations) (a) full and complete information about the ownership of a subcontractor (as defined in the Secretary's regulations) with whom the entity has had business transactions totalling more than $25,000 during the previous 12 months, and (b) full and complete information on any significant business transactions (as defined by the Secretary's regulations), occurring during the five-year period prior to the date of the request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

Section 3(c)(2) amends section 1903(i)(2) of the Social Security Act to add a new provision requiring termination of the Federal share of payments with respect to amounts paid for services furnished by

those entities who fail to comply with a specific request made by the Secretary as authorized under new clause (C) of section 1866(b)(2) or under new section 1902(a)(38).

Section 3(d) specifies that the amendments made by section 3(a)(1) will apply to certifications and recertification made (and program participation in the programs established by titles V, XVIII, and XIX of the Social Security Act pursuant to certifications and recertifications made), and fiscal intermediary or agent agreements or contracts enter into or renewed, on and after the date of the enactment of this legislation. The remaining amendments made by section 3 are to take effect on the date this legislation is enacted; except that the amendments made by sections 3(c)(1) and (2) are to become effective October 1, 1977.

SECTION 4. PENALTIES FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

Section 4(a) deletes existing section 1877 of the Social Security Act, entitled "Penalties," and replaces it with a new section 1877, also entitled, "Penalties." New section 1877(a) specifies that persons who commit fraudulent acts against the medicare program in connection with the furnishing of items and services (by that person) for which payment could be made under the medicare program will have committed a felony and if convicted could be fined a maximum of $25,000. or imprisoned for up to five years, or both. New section 1877(a) also specifies that other persons committing fraudulent acts against the medicare program would be guilty of a misdemeanor and if convicted could be fined a maximum of $10,000, imprisoned for up to one year, or both. Under the provisions of new section 1877(a), a person who commits a fraudulent act against the medicare program is anyone who:

(1) knowingly and willfully makes or causes to be made a false statement or representation of a material fact when applying for a benefit or payment under title XVIII.

(2) knowingly and willfully makes or causes to be made a false statement or representation of a material fact to use to determine rights to a benefit or payment under title XVIII.

(3) conceals or fails to disclose knowledge of an event, which affects (A) his initial or continued right to a benefit or payment under title XVIII, or (B) the initial or continued right of another individual on whose behalf he has applied for or is receiving a benefit or payment under title XVIII, with the fraudulent intent to secure the benefit or payment in a greater amount than is due him or when no benefit is authorized, or

(4) has applied to receive a benefit or payment under title XVIII for the use and benefit of another and after receiving it, knowingly and willfully converts it or any part of it to a use other than for the use and benefit of the other person.

New section 1877(b)(1) provides that persons will be guilty of a felony, and if convicted could be fined up to $25,000, imprisoned for up to five years, or both if they solicit or receive any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind:

(a) in return for referring an individual to a person who will furnish or arrange to furnish items or services for which payment may be made in whole or in part under the medicare program, or

(b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under the medicare program.

New section 1877(b)(2) provides that persons will be guilty of a felony, and if convicted could be fined up to $25,000, imprisoned for up to five years, or both if they offer or pay any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce that person:

(a) to refer an individual to a person who will furnish or arrange to furnish items or services for which payment may be made in whole or in part under the medicare program, or

(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under the medicare program.

New section 1877(b)(3) provides that a discount or other reduction in price obtained by a provider of services or other entity reimbursed under the medicare program on a cost basis would not be considered a felonious act under the provisions of new sections 1877(b)(1) and (b)(2), if the reduction in price is properly disclosed and reflected in the costs claimed by the provider or entity as reimbursable under the medicare program.

New section 1877(c) provides that persons will be guilty of a felony, and if convicted fined up to $25,000, imprisoned for up to five years or both, if they knowingly and willfully make or cause to be made, or induce or seek to induce the making of, any false statement or representation of a material fact about the conditions or operation of any institution or facility to assist that institution or facility to qualify under medicare (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as defined in section 1861 of the Social Security Act).

Section 4(b) deletes existing section 1909 of the Social Security Act, entitled "Penalties," and replaces it with a new section 1909, also entitled "Penalties." New section 1909(a) specifies that persons who commit fraudulent acts against the medicaid program in connection with the furnishing of items and services (by that person) for which payment could be made under medicaid will have committed a felony and if convicted could receive a maximum $25,000 fine, up to five years imprisonment, or both. New section 1909(a) also specifies that other persons committing fraudulent acts against the medicaid program are guilty of a misdemeanor, and if convicted, could receive a maximum $10,000 fine, up to five years imprisonment, or both. In addition, new section 1909(a) also provides that when a medicaid recipient is convicted of an offense against the medicaid program, as specified under new section 1909(a), a State may at its option (notwithstanding any

other provisions of title XIX of the Social Security Act or the State plan for medical assistance) limit, restrict, or suspend the eligibility of that recipient for a period it deems appropriate (but not to exceed one year). However, the imposition of this limitation, restriction, or suspension on the eligibility of any recipient cannot affect the eligibility of any other individual for medical assistance under a State plan, regardless of the relationship between the suspended recipient and that other individual. Under the provisions of new section 1909(a), a person who commits a fraudulent act against the medicaid program is anyone who:

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact when applying for any benefit or payment under a State plan for medical assistance approved under the title XIX of the Social Security Act,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact to use to determine rights to such benefit or payment under title XIX,

(3) conceals or fails to disclose knowledge of an event, which affects (A) his initial or continued right to a benefit or payment under a State plan for medical assistance, or, (B) the initial or continued right of another individual on whose behalf he has applied for or is receiving a benefit or payment under a State plan for medical assistance, with the fraudulent intent to secure the benefit or payment in a greater amount than is due him or when no benefit is authorized, or

(4) has applied to receive any such benefit or payment for the use and benefit of another and after receiving it, knowingly and willfully converts it or any part of it to a use other than for the use and benefit of the other person.

New section 1909(b)(1) provides that persons will be guilty of a felony, and if convicted could receive a maximum $25,000 fine, imprisonment for up to five years, or both, if they solicit or receive any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind;

(A) in return for referring an individual to a person who will furnish or arrange to furnish items or services for which payment may be made in whole or in part under the medicaid program, or

(B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under the medicaid program.

New section 1909(b)(2) provides that persons will be guilty of a felony, and if convicted could receive a maximum $25,000 fine, up to five years imprisonment, or both, if they offer or pay any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce that person:

(a) to refer an individual to a person who will furnish or arrange to furnish items or services for which payment may be made in whole or in part under the medicaid program, or

(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any items for which payment may be made in whole or in part under the medicaid program.

New section 1909(b)(3) specifies that a discount or other reduction in price obtained by a provider of services or other entity reimbursed under title XIX of the Social Security Act on a cost basis would not be considered a felonious act under the provisions of new sections 1909(b)(1) and (2), if the reduction in price is properly disclosed and reflected in the costs claimed by the provider or entity as reimbursable under the medicaid program.

New section 1909(c) provides that persons will be guilty of a felony, and if convicted, could receive a maximum fine of $25,000 up to five years imprisonment, or both if they knowingly and willfully make or cause to be made, or induce or seek to induce the making of, any false statement or representation of a material fact about the conditions or operation of any institution or facility to assist that institution or facility to qualify under a State plan for medical assistance (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as defined in section 1861 of the Social Security Act).

Section 4(c) amends section 204(a) of Public Law 94–505 (relating to annual reports of the Health, Education, and Welfare Inspector General) to also include in the annual report an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and any recommendations with respect to improving the performance of such activities.

Section 4(d) provides that the amendments made by subsections 4(a) and 4(b), with respect to penalties for fraudulent acts against the medicare or medicaid programs, apply only to those acts occurring or statements made on or after the date this legislation is enacted.

SECTION 5. AMENDMENTS RELATED TO PROFESSIONAL STANDARDS REVIEW ORGAIZATIONS

Section 5(a) of the bill amends section 1152(e) of the Social Security Act by substituting a new provision. The new section 1152(e) provides that where the Secretary finds a PSRO (whether designated on a conditional basis or otherwise) to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required by this Act (except under part B title XI) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such PSRO, except to the extent specified by the Secretary. This amended provision is not to be construed as rendering inapplicable any provision of this Act wherein requirements with respect to conditions for eligibility to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of medical necessity and quality made pursuant to section 1155(a)(1) and (2)) must be satisfied.

Section 5(b)(1) amends section 1154(b) of the Social Security Act by extending the conditional designation period for a period not to exceed 48 months (except as provided in the new section 1154(c)). Section 5(b)(1) clarifies the requirement of current law that PSRO's must assume responsibility for review of all services provided by or in institutions (including ancillary services) and any other services the Secretary may require during the trial period.

Section 5(b)(2) amends section 1154 of the Social Security Act by redesignating subsection (c) as subsection (d) and by inserting a new subsection (c). The new subsection (c) provides that if the Secretary finds that a conditionally designated organization has been unable to perform satisfactorily all of the required duties and functions for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

Section 5(c)(1) amends section 1155(a)(6) of the Social Security Act by precluding a physician from reviewing those services which he was directly responsible for providing or services furnished in an institution in which he or any member of his family has a significant financial interest. Section 5(c)(1) amends section 1155(f)(2) of the Social Security Act by providing that arrangements with PSRO's for reimbursement of the costs of review activities are to be made in a manner similar to that provided under section 1816(c) of the Social Security Act (pertaining to medicare intermediaries).

Section 5(c)(1) further amends section 1155 of the Social Security Act by striking the existing subsection (g) and substituting a new subsection.

The new section 1155(g)(1) provides that not later than two years after the date of enactment of this Act, the Secretary, through the conduct of demonstration projects or otherwise, shall develop effective ambulatory care review methodologies for use by PSRO's in performing review responsibility with respect to ambulatory care services.

The new section 1155(g)(2) provides that where a PSRO (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

The new section 1155(g)(3) provides that the Secretary shall require any PSRO which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not later than two years after the date the organization has been designated as a fully qualified PSRO.

Section 5(c)(2) amends section 1101(a) of the Social Security Act (definitions) by adding a new paragraph (9).

The new paragraph (9) defines "shared health facility". The term means any arrangement whereby—

(a) two or more health care practitioners practice their professions at a common physical location;

(b) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(c) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners; and

who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(d) at least one of such practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding $40,000 during the preceding 12 months.

The term "shared health facility" does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301 of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

Section 5(d)(1) amends section 1158 of the Social Security Act by adding a new subsection (c).

The new subsection (c) provides that where a PSRO (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations of medical necessity and appropriateness made pursuant to paragraphs (1) and (2) of section 1155(a) in connection with such reviews shall constitute the conclusive determination on those issues subject to the hearings and appeals provisions (section 1159 of the Act) and the requirements pertaining to memorandum of understanding and State monitoring (sections 1171(a)(1) and 1711(d)(3)) for purposes of payment. No reviews with respect to those determinations shall be conducted, for purposes of payment, by medicare intermediaries which are parties to agreements entered into by the Secretary pursuant to section 1816, medicare carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State medicaid agencies.

Section 5(d)(2)(A) amends section 1152(b)(2) of the Social Security Act to require the development and submission of a formal review plan in accordance with the new section 1152(h).

Section 5(d)(2)(B) adds a new section 1152(h). The new section 1152(h) requires an organization to consult with the appropriate single State medicaid agency during the development and preparation of its formal plan under section 1115(b)(2) or of any modi-

fication of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services. The plan or any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments. Before making findings pursuant to section 1152(b)(2) or a finding regarding the organization's capability to perform review of long-term care and ambulatory care services, the Secretary shall consider any comments submitted to him by the Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification. If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, he shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings become effective.

Section 5(d)(2)(C) amends section 1154 of the Social Security Act by adding a new subsection (e). The new subsection (e) requires the Secretary, in determining whether a conditionally designated PSRO is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, to follow the procedures specified in the new section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).

Section 5(d)(2)(D) adds a new section 1171 to the Social Security Act entitled: "Memorandums of Understanding; Federal-State Relations Generally".

The new section 1171(a)(1) specifies that (except as provided in paragraph (2)) no determination of appropriateness or medical necessity made by a PSRO pursuant to section 1155(a)(1) and (2) shall constitute conclusive determinations under section 1158(c) for purposes of payment under medicaid, unless such organization has entered into a memorandum of understanding, approval by the Secretary, with the appropriate single State medicaid agency. The memorandum of understanding shall delineate the relationship between the organization and the State agency and provide for the exchange of data or information, administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.

The new section 1171(a)(2) provides that the requirement of paragraph (1) may be waived by the Secretary if (a) the State agency indicates to him that it does not wish to enter into a memorandum of understanding with the organization involved, or (b) he finds that the State agency has refused to negotiate in good faith, or in a timely manner with such organization.

The new section 1171(b)(1) provides that the State agency may request a PSRO which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions.

The new section 1171(b)(2) provides that if the agency and organization cannot reach agreement regarding the inclusion of any such requested specification, the Secretary shall review the specification and require that it be included in the memorandum if he determines that such specification of goals or methods (a) is consistent with the functions of the organization and with the provisions of title XIX and the State's approved medicaid plan, and (b) does not seriously impact on the effectiveness and uniformity of the organization's review of health care services paid for under title XVIII and title XIX of the Act.

The new section 1171(c) provides that notwithstanding any other provision of the Act, the State agency may contract with any PSRO located in the State for the performance of review responsibilities in addition to those performed pursuant to part B of title XI. The cost of performance of such additional responsibilities is reimbursable as an expense of the State agency under section 1903(a)) if (1) the State agency formally requests the performance of such additional responsibilities, and (2) the performance of such additional responsibilities is not inconsistent with part B of title XI and is provided for in an amendment to the State's plan which is approved by the Secretary under title XIX.

The new section 1171(d)(1) provides that each State agency may monitor the performance of review responsibilities by PSRO's located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with the monitoring plan are reimbursable as an expense of the State agency under section 1903(a).

The new section 1171(d)(2) provides that a monitoring plan developed and approved under paragraph (1) may include a specification of performance criteria for judging the effectiveness of the review performance of the PSRO. If the State agency and the PSRO cannot reach agreement regarding such criteria, the Secretary shall assist the agency and organization in resolving the matters in dispute.

The new section 1171(d)(3) provides that whenever a State agency monitoring the performance of review responsibilities by a PSRO submits to the Secretary reasonable documentation that the review determinations of such organization have caused an unreasonable and detrimental impact either on total State medicaid expenditures or on the quality of care received by medicaid recipients and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, temporarily suspend such organization's authority in whole or in part under section 1158(c) to make conclusive determinations for purposes of payment under medicaid. He may also suspend such authority for purposes of payment under title XVIII. The temporary suspension shall be in effect pending a reevaluation of such organization's performance of the responsibilities involved and any appropriate action the Secretary may take as a result of such reevaluation. The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof. He shall notify the appropriate congressional committees of any such documentation submitted and the actions taken.

The new section 1171(e)(1) requires the Secretary to establish in a timely manner procedures and mechanisms to govern his relationships with State agencies under part B of title XI (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with representatives of the State agency and of PSRO's regarding relationships between them (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern. Such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a PSRO located within its State.

The new section 1171(e)(2) requires each PSRO to provide the appropriate State agency on request (a) data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and (b) such other data or information as the Secretary authorizes to be disclosed.

Section 5(d)(3)(A) of the bill amends section 1155(e)(1) of the Social Security Act by prohibiting delegated review in skilled nursing facilities.

Section 5(d)(3)(B) of the bill amends section 1155(a) by providing that required review specified in paragraph (1) is subject to the exceptions provided in the new paragraph (7).

The new paragraph (7) specifies that a PSRO has the function and duty to assume responsibility for the review of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)), only if the Secretary finds, on the basis of such documentation as he may require from the State, that the appropriate State medicaid agency is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions.

Section 5(e) amends section 1160(b)(1) of the Social Security Act to clarify that the sanctions provision applies to any health care practitioner or hospital, or other health care facility, agency, or organization subject to PSRO review.

Section 5(f) amends section 1163(a)(2) of the Social Security Act by substituting a new provision.

The new section 1163(a)(2) provides that members of the National PSR Council shall be appointed for a term of three years, except that of the members appointed in 1979, four shall be appointed for a term of only two years, and three for a term of only one year. Members of the Council shall be eligible for reappointment.

Section 5(g) deletes section 1163(f) of the Social Security Act pertaining to the requirement for an annual report prepared by the National Council.

Section 5(h) amends section 1166 of the Social Security Act by redesignating subsection (b) as subsection (d), adding new subsections (b), (c), and (e), and making appropriate changes in cross references.

The new section 1166(b) requires a PSRO to provide, in accordance with procedures established by the Secretary, data and information:

(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse. This data and information shall be provided by the PSRO to such agencies at their request at the discretion of the PSRO on the basis of its findings with respect to evidence of fraud or abuse.

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies authorized under title XV of the Public Health Service Act), in carrying out appropriate health care planning and related activities. The data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and the PSRO and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by the PSRO.

The new subsection (b) further provides that the existing penalty provision (redesignated as subsection (d)) shall not apply to the disclosure of any data and information received under this subsection. However, the penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information.

The new section 1166(d) provides that no patient record in the possession of a PSRO, a Statewide PSR Council, or the National PSR Council shall be subject to subpena or discovery proceedings in a civil action.

Section 5(i) amends section 1167 of the Social Security Act by adding a new subsection (d).

The new subsection (d) requires the Secretary to make payment to a PSRO (whether conditionally designated or qualified) or to any member or employee thereof, who furnishes legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred (as determined by the Secretary) in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function of such organization, member, or employee.

Section 5(j) amends section 1168 of the Social Security Act by adding a new sentence. The sentence clarifies that the Secretary is required to make payments for PSRO expenses from Federal funds without any requirement for the contribution of funds by any State or political subdivision.

Section 5(k) adds a new section 1172 to the Social Security Act entitled, "Annual Reports."

The new section 1172 requires the Secretary to submit to the Congress by April 1, 1978, and by April 1 of each subsequent year, a full and complete report on the administration, impact, and cost of the PSRO program during the preceding fiscal year. The report shall include data and information on:

(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all PSRO's participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by PSRO's , and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) services determined, in accordance with the provisions of part B of Title XI, to have been: (a) medically unnecessary, (b) furnished in an inappropriate setting, or (c) deficient in quality;

(4) the imposition of penalties and sanctions under title XI for violations of law and for failure to comply with the obligations imposed by part B of each title;

(5) the total costs incurred under titles V, XI, XVIII, and XIX of the Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

(6) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of PSRO's;

(7) the progress being made among PSRO's in adopting and implementing the ambulatory care review methodologies developed under section 1155(g)(1) of the Social Security Act;

(8) the results of program evaluation activities, including the operation of data collection systems and the status of PSRO data policy and implementation;

(9) the extent to which PSRO's are performing reviews of services for other governmental or private health insurance programs; and

(10) recommendations for legislative changes.

Section 5(l)(1) adds a new section 1125 which provides that no officer, employee, or agent of the United States, or any Professional Standards Review Organization or any person acting on behalf of such Organization, may inspect, acquire, or require the disclosure of, for any reason whatever, any individually identifiable medical record of a patient, unless the patient has properly authorized such inspection, acquisition, or disclosure.

The prohibition shall not apply to the inspection, acquisition, or disclosure of an individually identifiable medical record relating to medical care which is or was paid for (in whole or in part) under title V, XVIII, or XIX, if such inspection, acquisition, or disclosure is by a Professional Standards Review Organization, or any person acting on behalf of such Organization, for the purpose of performing utilization review with respect to such medical care, or is for the purpose of auditing for, investigating, or prosecuting fraud and abuse in the provision of, or payment for, such medical care.

A patient authorizes an inspection, acquisition, or disclosure of an individually identifiable medical record only if, in a signed and dated statement, he—

(1) authorizes the inspection, acquisition, or disclosure for a specific period of time;

(2) identifies the medical records authorized to be inspected, acquired, or disclosed;

(3) specifies the purposes for which the record may be inspected, acquired, or disclosed; and

(4) specifies the agencies which may inspect or acquire the record or to which the record may be disclosed.

Any person who violates the provisions of this section shall, upon conviction, be fined not more than $10,000 or imprisoned for not more than five years, or both. In addition to any other remedy contained in this Social Security Act or otherwise available, injunctive relief shall be available to any person aggrieved by a violation or threatened violation of this section. Also these provisions supersede any other law or any regulation of the United States which grants, or appears to grant, power or authority to any person to violate this provision except those statutes which are enacted after the date of enactment of this section and which specifically refer to this section.

For the purposes of this section, the term "individually identifiable medical record" means data or information that relates to the medical, dental, or mental condition or treatment of an individual and that is in a form which either identifies the individual or permits identification of the individual through means (whether direct or indirect) available to the public.

Subsection (2) requires the Secretary, after taking into consideration the recommendations contained in the final report of the Privacy Protection Study Commission (established under section 5 of the Privacy Act of 1974), to prepare and submit a report not later than three months after the date such Commission submits its final report. The report shall be submitted to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and to the Committee on Human Resources and the Committee on Finance of the Senate. The report shall contain specific recommendations (including draft legislation) for the timely development and implementation of appropriate procedures (including use of detailed written consent forms) in order to: (1) maintain the confidentiality of individually identifiable medical records (whether they relate to medical care provided directly by, or through the financial assistance of, the Federal Government or not), and (2) prevent the unwarranted inspection by, and disclosure to, Federal officers, employees, and agents and PSRO's of such records.

Section 5(m)(1) adds a new section 1173 to the Social Security Act entitled: "Medical Officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands To Be Included in the Professional Standards Review Program."

The new section 1173 provides that for purposes of the PSRO program (except for sections 1155(c) and 1163), individuals licensed to practice medicine in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands shall be considered to be physicians and doctors of medicine.

Section 5(m)(2) amends section 1101(a)(1) of the Social Security Act to specify that the term "State" includes American Samoa and the Trust Territory of the Pacific Islands.

Section 5(n) amends section 1861(w)(2) of the Social Security Act to provide funding from medicare trust funds for delegated review activities of services provided by a hospital which are covered under medicare part B.

Section 5(o) amends section 1167 of the Social Security Act to extend protection currently provided to members and employees of a PSRO from criminal prosecution or civil liability when carrying out PSRO functions to members and employees of statewide councils. The section modifies the section heading to reflect this change.

Section 5(p) makes clerical corrections in section 1152(b)(1)(A), section 1155(a)(1), and section 1160(b)(1) of the Social Security Act.

SECTION 6. ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

Section 6 amends part A of title XI of the Social Security Act (as already amended by section 3(a) of this legislation) to add a new section 1126 entitled, "Issuance of Subpenas by Comptroller General." New section 1126(a) gives the Comptroller General of the United States the power to sign and issue subpenas to any person to require that person to produce any pertinent books, records, documents, or other information as required by the General Accounting Office (GAO), in order to perform an audit, review, evaluation, or other function as authorized by law for any health program authorized under the Social Security Act. Subpenas issued by the Comptroller General can be served by anyone authorized by him (a) by delivering a copy of it to the person named in it, or (b) by registered mail or by certified mail addressed to the person at his last dwelling place or principal place of business. A verified return by the person serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt for it signed by the person served will be considered proof of service.

New section 1126(b) provides that in cases of resistance or refusal to obey a duly served subpena, the Comptroller General can apply to the U.S. District Court in which the person charged with resistance is found or resides or transacts business, for a court order to require the person to produce the information sought by the subpena. Persons failing to obey the court order could be considered in contempt by the Court. New section 1126(b) further specifies that when applying for a court order, the Comptroller General may be represented by GAO attorneys or by counsel employed by GAO without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title relating to classification and General Schedule pay rates.

New section 1126(c)(1) prohibits a GAO employee or officer from disclosing a personal medical record (as defined in new section 1126(c)(3)) to anyone, other than a GAO employee or officer whose official duties require disclosure of this information. If a GAO employee or officer illegally discloses a personal medical record, he will be fined

up to $1,000, imprisoned for up to six months, or both, and charged the costs of prosecution.

New section 1126(c)(2) provides an exception to the prohibition set forth in new section 1126(c)(1). It waives the penalties for disclosure of a personal medical record by a GAO employee or officer if disclosure is made to a Federal or State agency, recognized by the Secretary of HEW, to identify and investigate patterns or cases of fraud or abuse. However, before disclosing such information, the Comptroller General must determine that the record to be disclosed contains evidence of fraud and abuse.

New section 1126(c)(3) defines the term "personal medical record" to mean data or information:

(a) relating to the medical or mental condition or treatment of any individual;

(b) acquired by any GAO employee or officer in the course of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law for any health program authorized by the Social Security Act; and

(c) in a form which can be associated with, or otherwise identify, directly or indirectly, the individual.

New section 1126(d) prohibits personal medical records in the possession of GAO from being subject to subpena or discovery proceedings in a civil action.

SECTION 7. SUSPENSION OF PRACTITIONERS CONVICTED OF MEDICARE OR MEDICAID RELATED CLAIMS

Section 7(a) adds a new section 1862(e) to the Social Security Act.

The new section 1862(e)(1) of the Social Security Act provides that whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment, or within such prior period as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in medicare or medicaid, he shall suspend such physician or practitioner from participation in the medicare program for such period as he may deem appropriate. No payment may be made under medicare with respect to any item or service furnished by such physician or practitioner during the suspension period. The provisions relating to notification, hearings and judicial review (specified in section 1862(d) (2) and (3)) shall apply with respect to determinations made by the Secretary under this subsection.

The new section 1862(e)(2) provides that in any case where the Secretary suspends any physician or other individual practitioner from participation in medicare, he shall (a) promptly notify each single State medicaid agency of the fact, circumstances, and period of such suspension; and (b) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension; request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy; and request that such State or local agency or authority keep the Secretary and the Inspector General fully and currently informed with respect to any actions taken in response to such request.

Section 7(b) amends section 1902(a) of the Social Security Act by adding a new paragraph (39) and making the appropriate conforming changes.

The new Section 1902(a)(39) provides that (subject to the provisions of section 1902(g)) whenever the State medicaid agency is notified of a suspension action under medicare, it shall promptly suspend such physician or practitioner from participation in its medicaid program for not less than the period specified in the suspension notice, no payment may be made under its medicaid program with respect to any items or services furnished by such physician or practitioner during the suspension period.

Section 7(c) amends section 1902 of the Social Security Act by adding a new subsection (g).

The new section 1902(g) provides that the Secretary may waive suspension under medicaid if the single State medicaid agency submits a request to the Secretary for such waiver and if the Secretary approves such request.

Section 7(d) amends section 332(c) of the Public Health Service Act (relating to considerations in the designation of health manpower shortage areas) by adding a new paragraph (3).

The new paragraph (3) provides that the Secretary in determining whether to designate an area as a health manpower shortage area, shall take into consideration the extent to which individuals who are (1) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (2) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

Section 7(e) provides that the amendments made by section 7 shall apply with respect to determinations and designations made on or after the date of enactment. The amendment made by section 7(b) pertaining to medicaid suspensions shall become effective on October 1, 1977.

SECTION 8. DISCLOSURE OF PROVIDERS OF OWNERS AND CERTAIN OTHER INDIVIDUALS CONVICTED OF CERTAIN OFFENSES

Section 8(a) adds a new section 1127 to the Social Security Act entitled: "Disclosure by Institutions, Organizations, and Agencies of Owners and Certain Other Individuals Who Have Been Convicted of Certain Offenses."

The new section 1127(a) specifies that as a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee of such institution, organization, or agency, and

(2) has been convicted (on or after the date of enactment, or within such period prior to that date as the Secretary shall specify

in regulations) of a criminal offense related to the involvement of such person in any of such programs.

Section 1127(a) requires the Secretary or appropriate State agency to promptly notify the Inspector General of: 1) the receipt from any institution, organization, or agency or any application or request for such participation, certification, or recertification which discloses the name of any such person, and 2) the action taken with respect to such application or request.

The new section 1127(b) defines "managing employee" for purposes of this section. The term means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.

Section 8(b)(1) amends section 1866(a) of the Social Security Act by adding a new paragraph (3).

The new Section 1866(a)(3) provides that the Secretary may refuse to enter into or renew an agreement under medicare with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee of such provider, is a person described in the new section 1127(a).

Section 8(b)(2) amends section 1866(b)(2) of the Social Security Act by providing that the Secretary may terminate a provider agreement if he determines that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1127(a).

Section 8(c) amends section 1903 of the Social Security Act by adding a new subsection (n).

The new section 1903(n) provides that the medicaid State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an entity for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee of such entity is a person described in section 1127(a). This action may be taken whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under medicaid. Notwithstanding any other provisions of section 1903, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1127(a) at the time such contract or agreement was entered into or such approval was given.

Section 8(d) amends section 2002(a) of the Social Security Act by adding a new paragraph (15).

The new section 2002(a)(15) provides that any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under title XX or otherwise to approve a provider for such purposes, if any person who has a direct or

indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee is a person described in section 1127(a). The State may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately make any disclosure required of it by section 1127(a) at the time the contract or arrangement was entered into or the approval was given.

Section 8(e) provides that the amendments made by this section shall apply with respect to contracts, agreements, and arrangements entered into and approvals given pursuant to applications or requests made on and after the first day of the fourth month beginning after the date of enactment.

SECTION 9. FEDERAL ACCESS TO RECORDS

Section 9 amends section 1902(a)(27)(B) of the Social Security Act to require State plans to include provision for Federal access to records of persons or institutions providing services under medicaid in the same manner currently provided to State medicaid agencies.

SECTION 10. CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

Section 10(a) amends section 1903(a)(3)(B) of the Social Security Act by modifying the requirement for explanation of benefits forms required as a condition of increased Federal matching for operation of approved medicaid management information systems. The section provides that such notification shall be provided to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered.

Section 10(b) provides that the amendment made by subsection (a) shall apply with respect to calendar quarters beginning after the date of enactment.

SECTION 11. RESTRICTION ON FEDERAL MEDICAID PAYMENTS

Section 11(a) amends section 1903 of the Social Security Act by adding a new subsection (o), the new section 1903(o) provides that, notwithstanding the preceding provisions of section 1903, no Federal medicaid matching payments shall be made to a State for expenditures for medical assistance provided for an individual to the extent that private insurer (as defined by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or receiving medicaid benefits.

Section 11(b) provides that the amendment made by subsection (a) shall apply with respect to medical assistance provided under a State medicaid plan on and after January 1, 1978.

SECTION 12. STUDY AND REVIEW OF MEDICARE CLAIMS PROCESSING

Section 12 requires the Comptroller General of the United States to conduct a comprehensive study and review of the administrative

structure established for processing of claims under title XVIII of the Social Security Act. The study and review is for the purpose of determining whether and to what extent more efficient claims administration under such title could be achieved by:

(1) reducing the number of participating intermediaries and carriers;

(2) making a single organization responsible for the processing of claims under both part A and part B in a particular geographic area;

(3) providing for the performance of claims processing functions on the basis of a prospective fixed price;

(4) providing for other types of incentive payments for the most efficient organizations; or

(5) other modifications in such structure and related procedures.

The Comptroller General is required to submit to the Congress by July 1, 1979, a complete report setting forth the results of such study and review, together with his findings and his recommendations with respect thereto.

SECTION 13. ABOLITION OF PROGRAM REVIEW TEAMS UNDER MEDICARE

Section 13(a) deletes section 1862(d)(4) of the Social Security Act which provides for the establishment of program review teams under medicare.

Section 13(b)(1) amends section 1862(d)(1)(B) of the Social Security Act by deleting the reference to a program review team.

Section 13(b)(2) amends section 1862(d)(1)(C) of the Social Security Act by substituting a new provision.

The new section 1862(d)(1)(C) provides that no payment may be made under medicare, with respect to any item or service furnished by a person where the Secretary determines such person has furnished services or supplies which are substantially in excess of the needs of individuals or of a quality which fails to meet professionally recognized standards of health care. The Secretary's determination shall be on the basis of reports transmitted to him by PSRO's in accordance with section 1157 of the Social Security Act or, in the absence of any such report, on the basis of such data as he acquires in the administration of the medicare program.

Section 13(b)(3) amends section 1866(b)(2)(F) of the Social Security Act to specify that the Secretary may terminate a provider agreement where he determines that such provider has furnished services or supplies which are substantially in excess of the needs of individuals or of a quality which fails to meet professionally recognized standards of health care.

Section 13(b)(4) amends section 1157 of the Social Security Act by deleting the last sentence which relates to program review teams.

Section 13(c) provides that the amendments made by this section shall be effective on enactment.

SECTION 14. AMENDMENTS RELATING TO FISCAL INTERMEDIARIES

Section 14(a) amends section 1816 of the Social Security Act relating to fiscal intermediaries.

Section 14(a)(1) amends section 1816(a) to permit providers to be assigned to fiscal intermediaries in accordance with the new section 1816(e).

Section 14(a)(2) amends section 1816(b) by substituting a new provision.

The new section 1816(b) provides that the Secretary shall not enter into or renew an agreement with a fiscal intermediary unless he finds:

(a) after applying the standards, criteria, and procedures developed under the new subsection (f), that to do so is consistent with the effective and efficient administration of part A, and

(b) that such agency or organization is willing and able to assist the providers to which payments are made through it under part A in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits, and the agreement provides for such assistance. Further, the Secretary may not enter into an agreement unless such agency or organization agrees:

(1) to furnish him information acquired by it in carrying out its agreement, and

(2) to provide him with access to all data, information, and claims processing operations, as he may find necessary in performing his functions under part A.

Section 14(a)(3) amends the existing section 1816(e)(2) by providing that the Secretary's determination to terminate an agreement with a fiscal intermediary may not, in addition to the other criteria specified in existing law, be made until after applying the standards, criteria, and procedures developed under the new section 1816(f).

Section 14(a)(4) redesignates subsections (e), (f), and (g) of section 1816 of the Social Security Act as subsections (g), (h), and (i) respectively.

Section 14(a)(5) adds new sections 1816(e) and 1816(f) to the Social Security Act.

The new section 1816(e)(1) provides that, notwithstanding sections 1816(a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any fiscal intermediary which has entered into an agreement with him, if he determines, after applying the appropriate standards, criteria, and procedures developed under the new subsection (f), that such assignment or reassignment would result in more effective and efficient administration of part A.

The new section 1816(e)(2) provides that notwithstanding subsections (a) and (d) the Secretary may designate a national or regional agency or organization which has entered into a fiscal intermediary agreement to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the appropriate standards, criteria, and procedures developed under the new subsection (f), that such designation would result in more effective and efficient administration of part A.

The new section 1816(e)(3)(A) provides that before the Secretary makes an assignment or reassignment of a provider of services to other than the fiscal intermediary nominated by the provider, he

shall furnish the provider and such fiscal intermediary with a full explanation of the reasons for his determination. He is also required to furnish such fiscal intermediary with opportunity for a hearing and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

The new section 1816(e)(3)(B) provides that before the Secretary makes a designation of a national or regional fiscal intermediary with respect to a class of providers of services, he shall furnish such providers and the fiscal intermediaries adversely affected by such designation with a full explanation of the reasons for his determination. He is also required to furnish the fiscal intermediaries adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

The new section 1816(f) requires the Secretary to develop standards, criteria, and procedures in order to determine whether: 1) he should enter into, renew, or terminate an agreement with a fiscal intermediary, 2) he should assign or reassign a provider of services to a fiscal intermediary, and 3) he should designate an agency or organization to perform services with respect to a class of providers of services. Such standards, criteria, and procedures are to evaluate the overall performance of claims processing and other related functions required to be performed by fiscal intermediaries and the performance of such functions with respect to specific providers of services.

Section 14(b) requires the Secretary to develop the standards, criteria, and procedures described in the new section 1816(f) by October 1, 1978.

Section 14(c) provides that the amendments made by section 14(a)(2) and (3) to the extent that they require application of standards, criteria, and procedures developed under the new section 1816(f), shall apply to the entering into, renewal, or termination of agreements on and after October 1, 1978.

Section 14(d) specifies that, except as provided in subsection (c), the amendment made by subsection (a)(2) shall apply to agreements entered into or renewed on or after the date of enactment.

SECTION 15—DISCLOSURE BY PROVIDERS OF THE HIRING OF CERTAIN FORMER EMPLOYEES OF FISCAL INTERMEDIARIES

Section 15(a) amends section 1866(a)(1) of the Act (pertaining to provider agreements) to add a new subparagraph (D).

The new section 1866(a)(1)(D) requires a provider to have an agreement with the Secretary to promptly notify him of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of medicare) with respect to such provider.

Section 15(b) provdes that this section shall apply with respect to agreements entered into or renewed on and after the date of enactment.

SECTION 16. PAYMENT FOR DURABLE MEDICAL EQUIPMENT

Section 16(a) deletes existing section 1833(f) of the Social Security Act and replaces it with a new section 1833(f). New section 1833(f)(1) provides that, in the case of durable medical equipment to be furnished an individual as described in section 1861(s)(6) of the Social Security Act, the Secretary is to determine, on the basis of medical and other evidence that he finds appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants the presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that this presumption does exist, he must require that the equipment be purchased, on a lease-purchase basis or otherwise, and must pay for the equipment in accordance with the lease-purchase agreement (or in a lump-sum amount if the equipment is purchased other than on a lease-purchase basis). However, the Secretary can authorize the rental of equipment despite his determination that purchase would be less costly or more practical, if he otherwise determines that purchase of the equipment would be inconsistent with the purposes of the medicare program, or would create an undue financial hardship on the individual who will use it.

New section 1833(f)(2) permits the Secretary to waive the 20 percent coinsurance amount applicable under section 1833(a) of the Social Security Act for the purchase of used durable medical equipment, whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

New section 1833(f)(3) permits the Secretary to establish reimbursement procedures, pursuant to agreements made with suppliers of durable medical equipment, which he finds equitable, economical and feasible in order to purchase equipment as required under new section 1833(f)(1).

New section 1833(f)(4) requires the Secretary to encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under medicare on a lease-purchase basis whenever possible.

Section 16(b) specifies that the amendments made by section 16(a) apply to durable medical equipment purchased or rented on or after October 1, 1977.

SECTION 17. FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

Section 17(a) amends section 1903(a) of the Social Security Act (as already amended by section 2(b)(2) of this legislation) by redesignating section 1903(a)(7) as section 1903(a)(8) and inserting a new section 1903(a)(7). New section 1903(a)(7) would provide Federal matching assistance to each State with an approved State plan for medical assistance in order to establish and operate a State medicaid fraud control unit (including assistance to train personnel employed by such units). The Secretary would be required to pay each State an amount equal to 90 percent of the costs incurred during a quarter beginning on or before October 1, 1977, and ending before October 1, 1980, to establish and operate these units (as defined in

new section 1903(p)), if he finds that such assistance is necessary to eliminate fraud in the provision and administration of the State's medicaid program.

Section 17(b) amends section 1903(b) of the Social Security Act by adding a new section 1903(b)(3). New section 1903(b)(3) specifies that the amount of funds which the Secretary must pay a State during a quarter under new section 1903(a)(7), cannot exceed the higher of:

(a) $125,000, or

(b) one-quarter of 1 percent of the sums spent by the Federal, State, and local governments during the previous quarter in carrying out the State's plan for medical assistance under title XIX of the Social Security Act.

Section 17(c) amends section 1903 of the Social Security Act (as already amended by section 11(a) of this legislation) by adding a new section 1903(p). New section 1903(p) defines the term "State medicaid fraud control unit" (for the purposes of section 1903) to mean a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan for medical assistance under title XIX of the Social Security Act.

(3) The entity's function is conducting a statewide program to investigate and prosecute violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan for medical assistance under title XIX of the Social Security Act.

(4) The entity has procedures to review complaints of the abuse and neglect of patients in health care facilities which receive payments under the State plan for medical assistance approved under title XIX, and, where appropriate, of the Social Security Act to act upon these complaints under the criminal laws of the State or refer them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments made under the State plan for medical assistance to health care facilities which are discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of new section 1903(p).

Section 17(d)(1) specifies that the amendments made section 17(a) apply only to calendar quarters beginning after September 30, 1977.

Section 17(d)(2) requires the Secretary of HEW to establish regulations to carry out the amendments made under section 17 within 90 days after this legislation is enacted.

SECTION 18. REPORT ON HOME HEALTH AND OTHER IN-HOME SERVICES

Section 18(a) requires the Secretary of HEW, within one year after the enactment of this legislation, to submit to the appropriate committees of the Congress a report analyzing, evaluating, and making recommendations on all aspects (including the availability, administration, provision, reimbursement procedures, and cost) of the delivery of home health and other in-home services authorized to be provided under titles XVIII, XIX, and XX of the Social Security Act.

Section 18(b) requires the report to include an evaluation of the coordination of home health and in-home services provided under titles XVIII, XIX, and XX of the Social Security Act. The report must also include recommendations for changes in regulations and legislation on:

(1) the scope and definition of such services provided under such titles;

(2) the requirements for an individual to be eligible to receive such services under such titles;

(3) the standards for certification of providers of such services under such titles and (as appropriate) the uniformity of such standards for the programs under the different titles;

(4) procedures for control of utilization and assurance of quality of such services under such titles, including (as appropriate) the licensing and accreditation of agencies providing such services, a certification of need program with respect to the offering of such services, and the development and use of norms and standards for review of the utilization and quality of such services;

(5) methods of reimbursement for such services, including (A) methods of comparing costs incurred by providers of such services in order to determine the reasonableness of such costs and (B) methods which provide for more uniform reimbursement procedures under titles XVIII and XIX of the Social Security Act; and

(6) the prevention of fraud and abuse in the delivery of such services under such titles,

report is also to include the reasons for the recommendations made, an analysis of the impact of implementing such recommendations on the cost of home health and in-home services and the demand for these services, and the methods of financing any recommended increased provisions of these services under titles XVIII, XIX, and XX of the Social Security Act.

Section 18(c) requires the Secretary of HEW, when developing the report required under section 18, to consult with professional organizations, experts, and individual health professionals in the field of home health and other in-home services and with providers, private insurers, and consumers of such services.

SECTION 19. ESTABLISHMENT OF UNIFORM REPORTING SYSTEMS FOR DIFFERENT TYPES OF HEALTH SERVICES FACILITIES AND ORGANIZATIONS; MAKING OF REPORTS UNDER MEDICARE AND MEDICAID PROGRAMS IN ACCORDANCE WITH SUCH SYSTEMS

Section 19(a) amends part A of title XI of the Social Security Act by adding a new section 1121, entitled "Uniform Reporting Systems for Health Services Facilities and Organizations." New section 1121(a) requires the Secretary to establish, by regulation, a uniform system of reporting for hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations receiving payments under the Social Security Act.

New section 1121(a) further requires that for each type of health services facility or organization reporting under the uniform system, the following information will be required:

(1) the aggregate cost of operation and the aggregate volume of services;

(2) the costs and volume of services for various functional accounts and subaccounts;

(3) rates, by category of patient and class of purchaser;

(4) capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

(5) discharge and bill data.

In addition, new section 1121(a) requires that the uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act.

New section 1121(b) requires the Secretary to:

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

New section 1121(c) requires the Secretary to provide the information obtained through use of the uniform reporting system described in new section 1121(a) in a useful manner and format to appropriate agencies and organizations, including health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

Section 19(b)(1) amends section 1861(v)(1) of the Social Security Act by adding a new section 1861(v)(1)(F) which requires that regulations pertaining to the reasonable cost of services under the medicare program set forth under section 1861(v) must require each provider of services under the medicare program (other than a fund) to make reports to the Secretary on information in new section 1121(a) in accordance with the uniform reporting system (established under that section) for that type of provider.

Section 19(b)(2) amends section 1902(a) of the Social Security Act (as already amended by sections 2(b), 3(c), and 7(b) of this legislation) by adding a new section 1902(a)(40). New section 1902(a)(40) requires each health services facility or organization which receives payments under a State plan for medical asisstance and of a type for which a uniform reporting system has been established under new section 1121(a) to make reports to the Secretary on information described in that section in accordance with the uniform reporting system (established under that section) for that type of facility or organization.

Section 19(c)(1) requires the Secretary to establish the systems described in new section 1121(a) of the Social Security Act only after consultation with interested parties and:

(a) for hospitals, skilled nursing facilities, and intermediate care facilities, not later than the end of the one-year period, and

(b) for other types of health services facilities and organizations, not later than the end of the two-year period,

beginning on the date of enactment of this legislation.

Section 19(c)(2)(A) specifies that the amendments made by section 19(b) will apply, with respect to operations of a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the end of the six-month period beginning on the date a uniform reporting system is established (under new section 1121(a) of the Social Security Act) for that type of health services facility.

Section 19(c)(2)(B) specifies that the amendments made by section 19(b) will apply to the operation of a health services facility or organization other than a hospital, skilled nursing facility, or intermediate care facility, on and after the first day of its first fiscal year which begins after the date the Secretary determines appropriate for implementing the reporting requirements for that type of facility or organization.

Section 19(c)(2)(C) specifies that the amendments made by section 19(b)(2) will apply to State plans for medical assistance approved under title XIX of the Social Security Act, on and after October 1, 1977 (except as provided by sections (19(c)(2) (B) and (B)).

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is

enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman) :

SOCIAL SECURITY ACT

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

* * * * * * *

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in title V *and in part B of this title* also includes American Samoa and the Trust Territory of the Pacific Islands. Such term when used in titles III, IX, and XII also includes the Virign Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "States" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam.

* * * * * * *

(9) The term "shared health facility" means any arrangement whereby—

(A) two or more health care practitioners practice their professions at a common physical location;

(B) such practitioners share (i) common waiting areas, examining rooms, treatment rooms, or other space, (ii) the services of supporting staff, or (iii) equipment;

(C) such practitioners have a person (who may himself be a practitioner)—

(i) who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at such common physical location, other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) who makes available to such practitioners the services of supporting staff who are not employees of such practitioners; and

who is compensated in whole or in part, for the use of such common physical location or support services pertaining thereto, on a basis related to amounts charged or collected for the services rendered or ordered at such location or on any basis clearly unrelated to the value of the services provided by the person; and

(D) at least one of such practitioners received payments on

a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months, or in an aggregate amount exceeding $40,000 during the preceding 12 months;

except that such term does not include a provider of services (as defined in section 1861(u) of this Act), a health maintenance organization (as defined in section 1301 of the Public Health Services Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

* * * * * * *

UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

SEC. 1121. (a) For the purposes of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in, hospitals, skilled nursing facilities, intermediate care facilities, home health agencies, health maintenance organizations, and other types of health services facilities and organizations to which payment may be made under this Act, the Secretary shall establish by regulation, for each such type of health services facility or organization, a uniform system for the reporting by a facility or organization of that type of the following information:

(1) The aggregate cost of operation and the aggregate volume of services.

(2) The costs and volume of services for various functional accounts and subaccounts.

(3) Rates, by category of patient and class of purchaser.

(4) Capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment.

(5) Discharge and bill data.

The uniform reporting system for a type of health services facility or organization shall provide for appropriate variation in the application of the system to different classes of facilities or organizations within that type and shall be established, to the extent practicable, consistent with the cooperative system for producing comparable and uniform health information and statistics described in section 306(e)(1) of the Public Health Service Act.

(b) The Secretary shall—

(1) monitor the operation of the systems established under subsection (a);

(2) assist with and support demonstrations and evaluations of the effectiveness and cost of the operation of such systems and encourage State adoption of such systems; and

(3) periodically revise such systems to improve their effectiveness and diminish their cost.

(c) The Secretary shall provide information obtained through use of the uniform reporting system described in subsection (a) in a useful manner and format to appropriate agencies and organizations, in-

cluding health systems agencies (designated under section 1515 of the Public Health Service Act) and State health planning and development agencies (designated under section 1521 of such Act), as may be necessary to carry out such agencies' and organizations' functions.

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, and XIX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, and XIX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, or a renal disease facility;

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX; or

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 1816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1), with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

(c) A provider of services (as defined in section 1861(u), other than a fund) shall also include in the information supplied under subsection (a)(1) full and complete information as to the identity of each person with an ownership or control interest in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 per centum or more ownership interest.

DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE MEDICAL RECORDS

SEC. 1125. (a)(1) Notwithstanding any other provision of this Act except paragraph (2) of this subsection, no officer, employee, or agent of the United States, or any office, agency, or department thereof, or any Professional Standards Review Organization or any person acting or purporting to act on behalf of such Organization, may inspect, acquire, or require the disclosure of, for any reason whatever, any individually identifiable medical record of a patient, unless the patient has authorized such inspection, acquisition, or disclosure in accordance with subsection (b).

(2) The prohibition of paragraph (1) shall not apply to the inspection, acquisition, or disclosure of an individually identifiable medical record relating to medical care which is or was paid for (in whole or in part) under title V, XVIII, or XIX of this Act, if such inspection, acquisition, or disclosure (A) is by a Professional Standards Review Organization, or any person acting or purporting to act on behalf of such Organization, for the purpose of performing utilization review under part B of this title with respect to such medical care, or (B) is for the purpose of auditing for, investigating, or prosecuting fraud and abuse in the provision of, or payment for, such medical care.

(b) A patient authorizes an inspection, acquisition, or disclosure of an individually identifiable medical record for purposes of subsection (a) only if, in a signed and dated statement, he—

(1) authorizes the inspection, acquisition, or disclosure for a specific period of time;

(2) identifies the medical records authorized to be inspected, acquired, or disclosed;

(3) specifies the purposes for which the record may be inspected, acquired, or disclosed; and

(4) specifies the agencies which may inspect or acquire the record or to which the record may be disclosed.

(c) Any person who violates subsection (a), upon conviction, shall be fined not more than $10,000 or imprisoned for not more than five years, or both.

(d) In addition to any other remedy contained in this Act or otherwise available, injunctive relief shall be available to any person aggrieved by a violation or threatened violation of this section.

(e) The provisions of subsection (a) supersede any other law or any regulation of the United States which grants, or appears to grant,

power or authority to any person to violate subsection (a), except those statutes which are enacted after the date of enactment of this section and which specifically refer to this section.

(f) For the purposes of this section, the term "individually identifiable medical record" means data or information that relates to the medical, dental, or mental condition or treatment of an individual and that is in a form which either identifies the individual or permits identification of the individual through means (whether direct or indirect) available to the public.

ISSUANCE OF SUBPENAS BY COMPTROLLER GENERAL

SEC. 1126. (a) For the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under section 226, titles V, XVIII, or XIX, or part B of this title of this Act, the Comptroller General of the United States shall have power to sign and issue subpenas to any person requiring the production of any pertinent books, records, documents, or other information. Subpenas so issued by the Comptroller General shall be served by anyone authorized by him (1) by delivering a copy thereof to the person named therein, or (2) by registered mail or by certified mail addressed to such person at his last dwelling place or principal place of business. A verified return by the person so serving the subpena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post office receipt therefor signed by the person so served, shall be proof of service.

(b) In case of contumacy by, or refusal to obey a subpena issued pursuant to subsection (a) of this section and duly served upon, any person, any district court of the United States for the judicial district in which such person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Comptroller General, shall have jurisdiction to issue an order requiring such person to produce the books, records, documents, or other information sought by the subpena; and any failure to obey such order of the court may be punished by the court as a contempt thereof. In proceedings brought under this subsection, the Comptroller General may be represented by attorneys employed in the General Accounting Office or by counsel whom he may employ without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapters III and VI of chapter 53 of such title relating to classification and General Schedule pay rates.

(c)(1) Except as provided in paragraph (2), any employee or officer of the General Accounting Office who discloses a personal medical record (defined in paragraph (3)) to any person, other than an employee or officer of such Office whose official duties require disclosure of such information, shall be fined not more than $1,000 or imprisoned for not more than six months, or both, and charged the costs of prosecution.

(2) An employee or officer of the General Accounting Office who discloses a personal medical record to a Federal or State agency recognized by the Secretary as having responsibility for identifying

and investigating cases or patterns of fraud or abuse shall not be subject to the penalties of paragraph (1) if the Comptroller General has determined before the disclosure of such record that the record reveals evidence of fraud or abuse.

(3) For the purposes of this section, the term "personal medical record" means data or information—

(A) relating to the medical or mental condition or treatment of any individual;

(B) acquired by any employee or officer of the General Accounting Office in the course of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under section 226, titles V, XVIII, or XIX, or part B of this title of this Act; and

(C) in a form which can be associated with, or otherwise identify, directly or indirectly, the individual described in subparagraph (A).

(d) No personal medical record in the possession of the General Accounting Office shall be subject to subpena or discovery proceedings in a civil action.

DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1127. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, XIX, and XX, any hospital, nursing facility, or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health, Education, and Welfare of the receipt from any institution, organization, or agency of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section, the term "managing employee" means, with respect to an institution, organization, or agency, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day-to-day operations of the institution, organization, or agency.

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PART B—PROFESSIONAL STANDARDS REVIEW

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DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organization" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is voluntary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not restrict the eligibility of any member for service as an officer of the Professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)[(i)](*1*),

* * * * * * *

(2) an organization which the Secretary, on the basis of his examination and evaluation of a formal plan *which shall be developed and* submitted [to him] by the association, agency, or organization *in accordance with subsection* (*h*) (as well as on the basis of other relevant data and information), finds to be willing to perform and capable of performing, in an effective, timely, and objective manner and at reasonable cost, the duties, functions, and activities of a Professional Standards Review Organization required by or pursuant to this part.

* * * * * * *

[(e) In order to avoid duplication of functions and unnecessary review and control activities, the Secretary is authorized to waive any or all of the review, certification, or similar activities otherwise required under or pursuant to any provision of this Act (other than this part) where he finds, on the basis of substantial evidence of the effective performance of review and control activities by Professional Standards Review Organizations, that the review, certification, and similar activities otherwise so required are not needed for the provision of adequate review and control.]

(*e*) *Where the Secretary finds a Professional Standards Review Organization* (*whether designated on a conditional basis or otherwise*) *to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required pursuant to*

provisions of this Act (other than this part) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such Professional Standards Review Organization, except to the extent specified by the Secretary. Nothing in the preceding sentence shall be construed as rendering inapplicable any provision of this Act wherein requirements with respect to conditions for eligibility to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of the kind made pursuant to paragraphs (1) and (2) of section 1155(a)) must be satisfied.

* * * * * * *

(h)(1) During the development and preparation by an organization of its formal plan under subsection (b)(2) or of any modification of such plan to include review of services in skilled nursing facilities (as defined in section 1861(j)) or intermediate care facilities (as defined in section 1905(c)) or review of ambulatory care services, the organization shall consult with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located.

(2) Such plan and any such modification shall be submitted to the Governor of such State, at the time of its submission to the Secretary, for his comments.

(3) The Secretary, before making the findings described in subsection (b)(2) or a finding regarding the organization's capability to perform review of such services (as the case may be), shall consider any such comments submitted to him by such Governor before the end of the thirty-day period beginning on the date of submission of the plan or of any such modification (as the case may be).

(4) If, after considering such comments, the Secretary intends to make findings which are adverse to such comments, the Secretary shall provide the Governor making such comments with the opportunity to submit additional evidence and comments on such intended findings during a period of not less than thirty days ending before the findings become effective.

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TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed [24] *48* months *except as provided in subsection (c)*), the Secretary may require a Professional Standards Review Organization to perform, *in addition to review of health care services provided by or in institutions*, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organization to be capable of performing. The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided [or

ordered by physicians and other practitioners and institutional and other health care facilities, agencies, and organizations] *by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require.* Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

(*c*) *If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.*

[(c)] (*d*) Any agreement under which any organization is conditionally designated as the Professional Standards Review Organization for any area may be terminated by such organization upon 90 days notice to the Secretary or by the Secretary upon 90 days notice to such organization.

(*e*) *In determining whether an organization designated on a conditional basis as the Professional Standards Review Organization for any area is substantially carrying out its duties in a satisfactory manner and should be considered a qualified organization, the Secretary shall follow the procedures specified in section 1152(h) (concerning the Secretary's consideration of comments of the Governor of the State in which the organization is located).*

DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall [(subject to the provisions of subsection (g))] be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services (*except as provided in paragraph (7)*) and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

* * * * * * *

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly [or indirectly involved in] *responsible for* providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, [any] *a significant* financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(7) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions.

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(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital or other operating health care facility or organization *(other than a skilled nursing facility, as defined in section 1861(j))* located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity effectively and in timely fashion to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.

* * * * * * *

(f)(1) * * *

(2) Any such agreement with an organization under this part shall provide that the Secretary make payments to such organization, *in a manner similar to that provided for under section 1816(c)*, equal to the amount of expenses reasonably and necessarily incurred, as determined by the Secretary, by such organization in carrying out or preparing to carry out the duties and functions required by such agreement.

[(g) Notwithstanding any other provision of this part, the responsibility for review of health care services of any Professional Standards Review Organization shall be the review of health care services provided by or in institutions, unless such Organization shall have made a request to the Secretary that it be charged with the duty and function of reviewing other health care services and the Secretary shall have approved such request.]

(g) (1) Not later than two years after the date of the enactment of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, the Secretary, through the conduct of demonstration projects or otherwise, shall develop effective ambulatory care review methodologies for use by Professional Standards Review Organizations in performing review responsibility with respect to ambulatory care services.

(2) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

(3) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not later than two years after the date the organization has been designated as a Professional Standards Review Organization (other than under section 1154).

SUBMISSION OF REPORTS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1157. If, in discharging its duties and functions under this part, any Professional Standards Review Organization determines that any health care practitioner or any hospital, or other health care facility, agency, or organization has violated any of the obligations imposed by section 1160, such organization shall report the matter to the Statewide Professional Standards Review Council for the State in which such organization is located together with the recommendations of such Organization as to the action which should be taken with respect to the matter. Any Statewide Professional Standards Review Council receiving any such report and recommendation shall review the same and promptly transmit such report and recommendation to the Secretary together with any additional comments or recommendations thereon as it deems appropriate. [The Secretary may utilize a Professional Standards Review Organization, in lieu of a program review team as specified in sections 1862 and 1866, for purposes of subparagraph (C) of section 1862(d)(1) and subparagraph (F) of section 1866(b)(2).]

REQUIREMENT OF REVIEW APPROVAL AS CONDITION OF PAYMENT OF CLAIMS

SEC. 1158. (a) * * *

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(c) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsiblitiy with respect to specific types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155 (a) in connection with such reviews shall constitute the conclusive

determination on those issues (subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State agencies administering or supervising the administration of State plans approved under title XIX.

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1160. (a)(1) * * *

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(b)(1) If after reasonable notice and opportunity for discussion with the [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization* concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1157 (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization*, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this Act has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a), or

(B) by grossly and flagrantly violating any such obligation in one or more instances,

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently *or* for such period as the Secretary may prescribe) such [practitioner or provider] *health care practitioner or hospital, or other health care facility, agency, or organization* from eligibility to provide such services on a reimbursable basis.

* * * * * * *

NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a)(1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years [and shall be eligible for reappointment], *except that of the members appointed in 1979, four shall be appointed for a term of only two years, and three for a term of only one year. Members of the Council shall be eligible for reappointment.*

* * * * * * *

[(f) The National Professional Standards Review Council shall from time to time, but not less often than annually, submit to the Secretary and to the Congress a report on its activities and shall include in such report the findings of its studies and investigations together with any recommendations it may have with respect to the more effective accomplishment of the purposes and objectives of this part. Such report shall also contain comparative data indicating the results of review activities, conducted pursuant to this part, in each State and in each of the various areas thereof.]

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PROHIBITION AGAINST DISCLOSURE OF INFORMATION

SEC. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part [or (2)], *(2)* in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, *or (3) in accordance with subsection (b).*

(b) A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information—

(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such Organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse;

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as may be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such Organization, and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such Organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any data and information received under this subsection,

except that such penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information.

[(b)] *(c)* It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

(d) No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the National Professional Standards Review Council shall be subject to subpena or discovery proceedings in a civil action.

LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION, AND FOR MEMBERS AND EMPLOYEES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS *AND STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS,* AND FOR HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 1167. (a) Notwithstanding any other provision of law, no person providing information to any Professional Standards Review Organization *or to any Statewide Professional Standards Review Council*, shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) unless—

(1) such information is unrelated to the performance of the duties and functions of such Organization *or such Council*, or

(2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.

(b) (1) No individual who, as a member or employee of any Professional Standards Review Organization *or of any Statewide Professional Standards Review Council* or who furnishes professional counsel or services to such organization *or council*, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of Professional Standards Review Organizations *or of Statewide Professional Standards Review Councils* under this part, to have violated any criminal law, (or to be civilly liable under any law, of the United States or of any State (or political subdivision thereof) provided he has exercised due care.

(2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

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(d) The Secretary shall make payment to a Professional Standards Review Organization, whether conditionally designated or qualified, or to any member or employee thereof, or to any person who furnishes

legal counsel or services to such organization, in an amount equal to the reasonable amount of the expenses incurred, as determined by the Secretary, in connection with the defense of any suit, action, or proceeding brought against such organization, member, or employee related to the performance of any duty or function of such organization, member, or employee (as described in section 1155).

AUTHORIZATION FOR USE OF CERTAIN FUNDS TO ADMINISTER THE PROVISIONS OF THIS PART

SEC. 1168. Expenses incurred in the administration of this part shall be payable from—

(a) funds in the Federal Hospital Insurance Trust Fund;

(b) funds in the Federal Supplementary Medical Insurance Trust Fund; and

(c) funds appropriated to carry out the health care provisions of the several titles of this Act;

in such amounts from each of the sources of funds (referred to in subsections (a), (b), and (c)) as the Secretary shall deem to be fair and equitable after taking into consideration the costs attributable to the administration of this part with respect to each of such plans and programs. The Secretary shall make such transfers of moneys between the funds, referred to in clauses (a), (b) and (c) of the preceding sentence, as may be appropriate to settle accounts between them in cases where expenses properly payable from the funds described in one such clause have been paid from funds described in another of such clauses. *The Secretary shall make payments to Professional Standards Review Organizations (whether designated on a conditional basis or otherwise) from funds described in the first sentence of this section (without any requirement for the contribution of funds by any State or political subdivision thereof) for expenses incurred in the performance of duties by such Organizations.*

* * * * * * *

MEMORANDUMS OF UNDERSTANDING; FEDERAL-STATE RELATIONS GENERALLY

SEC. 1171. (a) (1) Except as provided in paragraph (2), no determination made by a Professional Standards Review Organization pursuant to paragraphs (1) and (2) of section 1155(a) in connection with reviews shall constitute conclusive determinations under section 1158 (c) for purposes of payment under title XIX, unless such organization has entered into a memorandum of understanding, approved by the Secretary, with the single State agency responsible for administering or supervising the administration of the State plan approved under title XIX for the State in which the organization is located (hereinafter in this section referred to as the "State agency") for the purpose of delineating the relationship between the organization and the State agency and of providing for the exchange of data or information, administrative procedures, coordination mechanisms, and modification of the memorandum at any time that additional responsibility for review by the organization is authorized by the Secretary.

(2) *The requirement of paragraph (1) may be waived by the Secretary if (A) the State agency indicates to the Secretary that it does not wish to enter into a memorandum of understanding with the organization involved, or (B) the Secretary finds that the State agency has refused to negotiate in good faith or in a timely manner with the organization involved.*

(b) (1) *The State agency may request a Professional Standards Review Organization which is entering into such a memorandum of understanding with the agency to include in the memorandum a specification of review goals or methods (additional to any such goals or methods contained in the organization's formal plan) for the performance of the organization's duties and functions under this part.*

(2) *If the agency and the organization cannot reach agreement regarding the inclusion of any such requested specification, the Secretary shall review such specification and shall require that the specification be included in the memorandum if the Secretary determines that such specification of goals or methods (A) is consistent with the functions of the organization under this part and with the provisions of title XIX and the State's plan approved under such title, and (B) does not seriously impact on the effectiveness and uniformity of the organization's review of health care services paid for under title XVIII and title XIX of this Act.*

(c) *Notwithstanding any other provision of this Act, the State agency may contract with any Professional Standards Review Organization located in the State for the performance of review responsibilities in addition to those performed pursuant to this part (and the cost of performance of such additional responsibilities is reimbursable as an expense of the State agency under section 1903(a)) if—*

(1) the State agency formally requests the performance of such additional responsibilities, and

(2) the performance of such additional responsibilities is not inconsistent with this part and is provided for in an amendment to the State's plan which is approved by the Secretary under title XIX.

(d) (1) *Each State agency may monitor the performance of review responsibilities by Professional Standards Review Organizations located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with such plan are reimbursable as an expense of the State agency under section 1903(a).*

(2) *A monitoring plan developed and approved under paragraph (1) may include a specification of performance criteria for judging the effectiveness of the review performance of the Professional Standards Review Organizations. If the State agency and the Professional Standards Review Organizations cannot reach agreement regarding such criteria, the Secretary shall assist the agency and organizations in resolving the matters in dispute.*

(3) (A) *Whenever a State agency monitoring the performance of review responsibilities by a Professional Standards Review Organization under a plan developed and approved under paragraph (1) submits to the Secretary reasonable documentation that the review deter-*

minations of such organization have caused an unreasonable and detrimental impact either on total State expenditures under title XIX or on the quality of care received by individuals under the State's plan approved under such title, and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, temporarily suspend such organization's authority in whole or in part under section 1158(c) to make conclusive determinations for purposes of payment under title XIX (and he may suspend such authority for purposes of payment under title XVIII) pending a reevaluation of such organization's performance of the responsibilities involved and any appropriate action the Secretary may take as a result of such reevaluation.

(B) The Secretary shall notify the State agency submitting such documentation, and the organization involved, in writing, of his determination, any subsequent actions taken, and the basis thereof, and shall notify the appropriate committees of the United States House of Representatives and the Senate of any such documentation submitted and the actions taken.

(e) (1) The Secretary shall in a timely manner establish procedures and mechanisms to govern his relationships with State agencies under this part (specifically including his relationships with such agencies in connection with their respective functions under the preceding provisions of this section). Such mechanisms shall include periodic consultation by the Secretary with State agency representatives and representatives of Professional Standards Review Organizations regarding relationships between such agencies and such organizations (including the appropriate exchange of data and information between such agencies and such organizations) and other problems of mutual concern, and such procedures shall permit the State agency to be represented on any project assessments conducted by the Secretary with respect to a Professional Standards Review Organization located within its State.

(2) Each Professional Standards Review Organization shall provide to the State agency for the State in which it is located, upon request, data or information which the Secretary requires such organizations to report to him routinely on a periodic basis, and such other data or information as the Secretary authorizes to be disclosed.

ANNUAL REPORTS

SEC. 1172. The Secretary shall submit to the Congress not later than April 1, 1978, and not later than April 1 of each year thereafter, a full and complete report on the administration, impact, and cost of the program under this part during the preceding fiscal year, including data and information on—

(1) the number, status (conditional or otherwise), and service areas of, and review methodologies employed by, all Professional Standards Review Organizations participating in the program;

(2) the number of health care institutions and practitioners whose services are subject to review by Professional Standards Review Organizations, and the number of beneficiaries and recipients who received services subject to such review during such year;

(3) services determined, in accordance with the provisions of this part, to have been (A) medically unnecessary, (B) furnished in an inappropriate setting, or (C) deficient in quality;

(4) the imposition of penalties and sanctions under this title for violations of law and for failure to comply with the obligations imposed by this part;

(5) the total costs incurred under titles V, XI, XVIII, and XIX of this Act in the implementation and operation of all procedures required by such titles for the review of services to determine their medical necessity, appropriateness of use, and quality;

(6) changes in utilization rates and patterns, and changes in medical procedures and practices, attributable to the activities of Professional Standards Review Organizations;

(7) the progress being made among Professional Standards Review Organizations in adopting and implementing the ambulatory care review methodologies developed under section 1155(g)(1);

(8) the results of program evaluation activities, including the operation of data collection systems and the status of Professional Standards Review Organization data policy and implementation;

(9) the extent to which Professional Standards Review Organizations are performing reviews of services for other governmental or private health insurance programs; and

(10) recommendations for legislative changes.

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part (except sections 1155(c) and 1163) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

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PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

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(c) No payment which may be made to a provider of services under this title for any service furnished to an individual shall be made to any other person under an assignment or power of attorney; but

nothing in this subsection shall be construed (1) to prevent the making of such a payment in accordance with an assignment from the provider if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (2) to preclude an agent of the provider of services from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such provider under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (*and to providers assigned to such agency or organization under subsection (e)*), and for the making of such payments by such agency or organization to such providers (*and to providers assigned to such agency or organization under subsection (e)*). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of this part, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in

carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part.]

(b) The Secretary shall not enter into or renew an agreement with any agency or organization under this section unless—

(1) he finds—

(A) after applying the standards, criteria, and procedures developed under subsection (f), that to do so is consistent with the effective and efficient administration of this part, and

(B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance; and

(2) such agency or organization agrees—

(A) to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section, and

(B) to provide the Secretary with access to all such data, information, and claims processing operations,

as the Secretary may find necessary in performing his functions under this part.

* * * * * * *

(e)(1) Notwithstanding subsections (a) and (d), the Secretary, after taking into consideration any preferences of providers of services, may assign or reassign any provider of services to any agency or organization which has entered into an agreement with him under this section, if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such assignment or reassignment would result in the more effective and efficient administration of this part.

(2) Notwithstanding subsections (a) and (d), the Secretary may designate a national or regional agency or organization which has entered into an agreement with him under this section to perform functions under the agreement with respect to a class of providers of services in the Nation or region (as the case may be), if he determines, after applying the standards, criteria, and procedures developed under subsection (f), that such designation would result in more effective and efficient administration of this part.

(3)(A) Before the Secretary makes an assignment or reassignment under paragraph (1) of a provider of services to other than the agency or organization nominated by the provider, he shall furnish (i) the provider and such agency or organization with a full explanation of the reasons for his determination as to the efficiency and effectiveness of the agency or oragnization to perform the functions required under this part with respect to the provider, and (ii) such agency or organization with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(B) Before the Secretary makes a designation under paragraph (2) with respect to a class of providers of services, he shall furnish (i) such providers and the agencies and organizations adversely

affected by such designation with a full explanation of the reasons for his determination as to the efficiency and effectiveness of such agencies and organizations to perform the functions required under this part with respect to such providers, and (ii) the agencies and organizations adversely affected by such designation with opportunity for a hearing, and such determination shall be subject to judicial review in accordance with chapter 7 of title 5, United States Code.

(f) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of service to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (1) overall performance of claims processing and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (2) performance of such functions with respect to specific providers of services.

[e] (*g*) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, *after applying the standards, criteria and procedures developed under subsection (f) and* after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

[f] (*h*) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

[g] (*i*) (1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence of intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

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[(f) (1) In the case of the purchase of durable medical equipment included under section 1861 (s) (6), by or on behalf of an individual, payment shall be made in such amounts as the Secretary determines to be equivalent to payments that would have been made under this part had such equipment been rented and over such period of time as the Secretary finds such equipment would be used for such individual's medical treatment, except that (A) payment may be made in a lump sum if the Secretary finds that such method of payment is less costly or more practical than periodic payments, and (B) with respect to purchases of used equipment the Secretary is authorized to waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

[(2) In the case of rental of durable medical equipment the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible.]

(f) (1) In the case of durable medical equipment to be furnished an individual as described in section 1861 (s) (6), the Secretary shall determine, on the basis of such medical and other evidence as he finds appropriate (including certification by the attending physician with respect to expected duration of need), whether the expected duration of the medical need for the equipment warrants a presumption that purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it.

(2) With respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

(3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medical equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible.

(4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under this title on a lease-purchase basis whenever possible.

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
(b)(1) * * *

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(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. *No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.*

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PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title.

Spell of Illness

(a) * * *

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Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * * * *

[(11) supplies full and complete information to the Secretary or his delegate as to the identity (A) of each person who has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (B) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (C) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied:]

(11) complies with the requirements of section 1124;

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Reasonable Cost

(v)(1)(A) * * *

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(*F*) *Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.*

Arrangements for Certain Services

(w)(1) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

(2) Utilization review activities conducted, in accordance with the requirements of the program established under part B of title XI of the Social Security Act with respect to services furnished by a hospital to patients insured under part A of this title or entitled to have payment made for such services under *part B of this title or under* a State plan approved under title V or XIX, by a Professional Standards Review Organization designated for the area in which such hospital is located shall be deemed to have been conducted pursuant to arrangments between such hospital and such organization under which such hospital is obligated to pay to such organization, as a condition of receiving payment for hospital services so furnished under this part or under such a State plan, such amount as is reasonably incurred

and requested (as determined under regulations of the Secretary) by such organization in conducting such review activities with respect to services furnished by such hospital to such patients.

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EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

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(d)(1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds[, with the concurrence of the appropriate program review team appointed pursuant to paragraph (4),] to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

(C) has furnished services or supplies which are determined by the Secretary, [with the concurrence of the members of the appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field,] to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality] *on the basis of reports transmitted to him in accordance with section 1157 of this Act (or, in the absence of any such report, on the basis of such data as he acquires in the administration of the program under this title), to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.*

* * * * * * *

[(4) For the purposes of paragraph (1)(B) and (C) of this subsection, and clause (F) of section 1866(b)(2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and the consumer representatives) in each State which shall, among other things—

[(A) undertake to review such statistical data on program utilization as may be submitted by the Secretary,

[(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto,

[(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1)(B) and (C) of this subsection or clause (F) of section 1866(b)(2), and

[(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases.]

(e)(1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the program under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.

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AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or

for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person[.], *and*

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.

* * * * * * *

(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1127(b)) of such provider, is a person described in section 1127(a).

(b) An agreement with the Secretary under this section may be terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1))—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined

(A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (*i*) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, *or* (*ii*) *to supply* (*within such period as may be specified by the Secretary in regulations*) *upon request specifically addressed to such provider by the Secretary* (*I*) *full and complete information as to the ownership of a subcontractor* (*as defined by the Secretary in regulations*) *with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and* (*II*) *full and complete information as to any significant business transactions* (*as defined by the Secretary in regulations*), *occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor*, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary [, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1862(d)(4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality] *to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or* (*G*) *that such provider* (*at the time the agreement was entered into*) *did not fully and accurately make any disclosure required of it by section 1127*(*a*).

* * * * * * *

PENALTIES

SEC. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or pay-

ment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

[shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.]

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year or both.

[(b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

[(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.]

(b) (1) Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever offers or pays any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer

to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to a discount or other reduction in price obtained by a provider of services or other entity reimbursed under this title on a cost basis if the reduction in price is properly disclosed and reflected in the costs claimed by the provider or entity as reimburable under this title.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$2,000] *$25,000* or imprisoned for not more than [6 months] *five years*, or both.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency *or the Secretary* with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency *or the Secretary* may from time to time request;

* * * * * * *

(32) provide that no payment under the plan for any care or service provided to an individual [by a physician, dentist, or other individual practitioner shall be made to anyone other than such

individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist, or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;] *shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—*

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service; and

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

* * * * * * *

[(35) effective January 1, 1973, provide that any intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) and ownership interest of 10 per centum or more in such intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C)

in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and]

(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization[.] ;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 60 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000 and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor;

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of a State plan approved under title XIX is notified by the Secretary under section 1862(e)(2)(A) that a physician or other

individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in its plan under this title for not less than the period specified in such notice, and no payment may be made under its plan with respect to any items or service furnished by such physician or practitioner during the period of the suspension under this title; and

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization.

* * * * * * *

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

* * * * * * *

(g) The Secretary may waive suspension under subsection (a)(39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for items or services furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of a State plan approved under title XIX such plan submits a request to the Secretary for such waiver and if the Secretary approves such request.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966

(1) * * *

* * * * * * *

(3) an amount equal to—

(A)(i) * * *

* * * * * * *

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, *or to each individual in a sample group of individuals who are furnished such services*, of the specific services (*other than confidential services*) so covered, the name of the person or persons furnishing the services, the date or dates on which

the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus

(6) subject to subsection (l), an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the arranging and providing of such programs of educational and technical assistance (provided through such means, including outreach offices, the media, and telephone hotlines, as the Secretary determines to be appropriate) to health care practitioners who furnish, through individual or group practices or through shared health facilities, services covered under the plan, as the Secretary determines are likely to expedite the filing and payment of claims for payment for such services provided by such practitioners; plus

(7) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (p); plus

[(6)] *(8)* and amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(7) may not exceed the higher of—

(A) $125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent

that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth and fifth sentences of section 1842(b)(3); or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), *or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38)*; or

* * * * * * *

(l)(1) Payment shall not be made under subsection (a)(6) for a quarter ending after September 30, 1980.

(2) If the aggregate of the amounts of payments to be made in accordance with subsection (a)(6) for any calendar quarter to States exceeds $1,250,000, the amount of the payment to be made under such subsection for the quarter to each such State shall be an amount which bears the same ratio to the amount determined for the quarter under the subsection to the State as $1,250,000 bears to the amount required to make payments for the quarter in accordance with such subsection to all of the States.

* * * * * * *

(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1127(b)) of such institution, organization, or agency, is a person described in section 1127(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 or is subject to a suspension of payment order issued under subsection (j) of this section); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1127(a) at the time such contract or agreement was entered into or such approval was given.

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments made under the State plan to health care facilities and discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

* * * * * * *

PENALTIES

SEC. 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such

benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

[shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.]

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the elgibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

[(b) Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any—

[(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

[(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.]

(b)(1) Whoever solicits or receives any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering goods, fa-

cilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

(2) Whoever offers or pays any remuneration (including kickbacks, bribes, or rebates, but excluding any amount paid by an employer to an employee for employment in the provision of covered items or services) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering goods, facilities, services, or any item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and, upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

(3) Paragraphs (1) and (2) shall not apply to a discount or other reduction in price obtained by an entity reimbursed under this title on a cost basis if the reduction in price is properly disclosed and reflected in the costs claimed by the entity as reimbursable under this title.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a [misdemeanor] *felony* and upon conviction thereof shall be fined not more than [$2,000] *$25,000* or imprisoned for not more than [6 months] *five years*, or both.

* * * * * * *

TITLE XX—GRANTS TO STATES FOR SERVICES

* * * * * * *

PAYMENTS TO STATES

SEC. 2002. (a) (1) * * *

* * * * * * *

(15) Any State may refuse to enter into a contract or other arrangement with a provider of services for purposes of participation under the program established by this title, or otherwise to approve a provider for such purposes, if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1127(b)) of such provider, is a person described in section 1127(a), and may terminate any such contract, arrangement, or approval if it determines that the provider did not fully and accurately

make any disclosure required of it by section 1126(a) at the time the contract or arrangement was entered into or the approval was given.

* * * * * * *

SECTION 332 OF THE PUBLIC HEALTH SERVICE ACT

DESIGNATION OF HEALTH MANPOWER SHORTAGE AREAS

SEC. 332. (a)(1) * * *

* * * * * * *

(c) In determining whether to make a designation, the Secretary shall take into consideration the following:

(1)(A) The recommendations of each health systems agency (designated under section 1515) for a health service area which includes all or any part of the area, population group, medical facility, or other public facility under consideration for designation.

(B) The recommendations of the State health planning and development agency (designated under section 1521) if such area, population group, medical facility, or other public facility is within a health service area for which no health systems agency has been designated.

(2) The recommendations of the Governor of each State in which the area, population group, medical facility, or other public facility under consideration for designation is in whole or part located.

(3) The extent to which individuals who are (A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and (B) entitled to have payment made for medical services under title XVIII or XIX of the Social Security Act, cannot obtain such services because of suspension of physicians from the programs under such titles.

* * * * * * *

SECTION 204 OF THE ACT OF OCTOBER 15, 1976

(Public Law 94–505)

AN ACT To authorize conveyance of the interests of the United States in certain lands in Salt Lake County, Utah, to Shriners' Hospitals for Crippled Children, a Colorado corporation.

* * * * * * *

TITLE II—OFFICE OF INSPECTOR GENERAL

* * * * * * *

REPORTS

SEC. 204. (a) The Inspector General shall, not later than March 31 of each year, submit a report to the Secretary and to the Congress

summarizing the activities of the Office during the preceding calendar year. Such report shall include, but need not be limited to—

(1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;

(2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1);

(3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and

(4) a summary of matters referred to prosecutive authorities and the extent to which prosecutions and convictions have resulted.

Such report shall also include an evaluation of the performance of the Attorney General in the investigation and prosecution of criminal violations relating to fraud in the programs of health insurance and medical assistance provided under titles XVIII and XIX of the Social Security Act, and shall include any recommendations with respect to improving the performance of such activities.

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